



Implant Consultation

This questionnaire was designed to provide important facts regarding the history of your pain or condition. The information you provide will assist in reaching a diagnosis and determining the best treatment. Please take your time and answer each question as completely and honestly as possible.

PATIENT INFORMATION

TODAY'S DATE: _____

MR. MS MISS MRS. DR. Name: _____
FIRST MIDDLE INITIAL LAST

AGE: _____ DATE OF BIRTH: _____ MALE FEMALE

ADDRESS: _____ CITY/STATE/ZIP: _____

E-MAIL ADDRESS: _____

MOBILE TELEPHONE NUMBER: _____

HOW LONG AT CURRENT ADDRESS? _____ (IF LESS THAN 3 YEARS, PLEASE GIVE PREVIOUS ADDRESS.)

PREVIOUS ADDRESS: _____

EMPLOYED BY: _____ OCCUPATION: _____

ADDRESS: _____

REFERRED BY: _____

SS#: _____ HOME PHONE: _____ WORK PHONE: _____

ADDRESS IF DIFFERENT FROM PATIENT: _____

FAMILY PHYSICIAN: _____

ADDRESS: _____

FAMILY DENTIST/Previous Dentist: _____

ADDRESS: _____

DO ANY OF THE FOLLOWING CHIEF COMPLAINTS APPLY TO YOU?

- | | |
|--|---|
| Y <input type="checkbox"/> N <input type="checkbox"/> Diet limited to semisolid or soft foods | Y <input type="checkbox"/> N <input type="checkbox"/> Jaw locks |
| Y <input type="checkbox"/> N <input type="checkbox"/> Mouth sores | <input type="checkbox"/> Upper <input type="checkbox"/> Lower |
| Y <input type="checkbox"/> N <input type="checkbox"/> Diet limited to liquid foods | Y <input type="checkbox"/> N <input type="checkbox"/> Limited opening of jaw |
| Y <input type="checkbox"/> N <input type="checkbox"/> Numbness in lower lip | Y <input type="checkbox"/> N <input type="checkbox"/> Teeth do not meet properly |
| Y <input type="checkbox"/> N <input type="checkbox"/> Difficulty chewing | Y <input type="checkbox"/> N <input type="checkbox"/> Loss of teeth |
| Y <input type="checkbox"/> N <input type="checkbox"/> Numbness in jawbone | Y <input type="checkbox"/> N <input type="checkbox"/> Poorly fitting dental appliance |
| Y <input type="checkbox"/> N <input type="checkbox"/> Difficulty speaking | Y <input type="checkbox"/> N <input type="checkbox"/> Pain in jaw joint |
| Y <input type="checkbox"/> N <input type="checkbox"/> Tingling in jawbone | Y <input type="checkbox"/> N <input type="checkbox"/> Gagging easily |
| Y <input type="checkbox"/> N <input type="checkbox"/> Nutritional disorders | Y <input type="checkbox"/> N <input type="checkbox"/> Pain when swallowing |
| Y <input type="checkbox"/> N <input type="checkbox"/> Digestive problems | Y <input type="checkbox"/> N <input type="checkbox"/> Head pain |
| Y <input type="checkbox"/> N <input type="checkbox"/> Pain in jaw bone | Y <input type="checkbox"/> N <input type="checkbox"/> Jaw clicks |
| Y <input type="checkbox"/> N <input type="checkbox"/> Facial pain | Y <input type="checkbox"/> N <input type="checkbox"/> Other |
| Y <input type="checkbox"/> N <input type="checkbox"/> Are you currently in pain? _____ | |
| Y <input type="checkbox"/> N <input type="checkbox"/> Do you feel your oral condition is affecting your general health in any way? _____ | |

LIST ANY MEDICATIONS/SUBSTANCES WHICH HAVE CAUSED AN ALLERGIC REACTION:

- | | |
|--|---|
| Y <input type="checkbox"/> N <input type="checkbox"/> Antibiotics | Y <input type="checkbox"/> N <input type="checkbox"/> Metals |
| Y <input type="checkbox"/> N <input type="checkbox"/> Aspirin | Y <input type="checkbox"/> N <input type="checkbox"/> Plastic |
| Y <input type="checkbox"/> N <input type="checkbox"/> Barbiturates | Y <input type="checkbox"/> N <input type="checkbox"/> Sedative |
| Y <input type="checkbox"/> N <input type="checkbox"/> Codeine | Y <input type="checkbox"/> N <input type="checkbox"/> Sleeping pill |
| Y <input type="checkbox"/> N <input type="checkbox"/> Lidocaine | Y <input type="checkbox"/> N <input type="checkbox"/> Local anesthetics |
| Y <input type="checkbox"/> N <input type="checkbox"/> Latex | Y <input type="checkbox"/> N <input type="checkbox"/> Other |

LIST MEDICATIONS/SUBSTANCES YOU ARE CURRENTLY TAKING:

- | | |
|--|--|
| Y <input type="checkbox"/> N <input type="checkbox"/> Antibiotics | Y <input type="checkbox"/> N <input type="checkbox"/> Cortisone |
| Y <input type="checkbox"/> N <input type="checkbox"/> Insulin | Y <input type="checkbox"/> N <input type="checkbox"/> Sulfa Drugs |
| Y <input type="checkbox"/> N <input type="checkbox"/> Anticoagulants | Y <input type="checkbox"/> N <input type="checkbox"/> Ginko Biloba |
| Y <input type="checkbox"/> N <input type="checkbox"/> Muscle Relaxants | Y <input type="checkbox"/> N <input type="checkbox"/> Diet pills |
| Y <input type="checkbox"/> N <input type="checkbox"/> Barbiturates | Y <input type="checkbox"/> N <input type="checkbox"/> Heart medication |
| Y <input type="checkbox"/> N <input type="checkbox"/> Nerve pills | Y <input type="checkbox"/> N <input type="checkbox"/> Tranquilizers |
| Y <input type="checkbox"/> N <input type="checkbox"/> Blood thinners | Y <input type="checkbox"/> N <input type="checkbox"/> Medications for osteoporosis |
| Y <input type="checkbox"/> N <input type="checkbox"/> Pain medication | Y <input type="checkbox"/> N <input type="checkbox"/> Bisphosphonates |
| Y <input type="checkbox"/> N <input type="checkbox"/> Codeine | Y <input type="checkbox"/> N <input type="checkbox"/> Herbal supplements |
| Y <input type="checkbox"/> N <input type="checkbox"/> Sleeping pills | |
| Y <input type="checkbox"/> N <input type="checkbox"/> Other _____ | |

MEDICAL HISTORY (Please indicate dates on questions checked YES)

- | | | | |
|---|---|---|---------------------------------|
| Y <input type="checkbox"/> N <input type="checkbox"/> | Abnormal bleeding after surgery/Injury | Y <input type="checkbox"/> N <input type="checkbox"/> | Heart disorder |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Anemia | Y <input type="checkbox"/> N <input type="checkbox"/> | Heart pacemaker |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Allergic Rhinitis | Y <input type="checkbox"/> N <input type="checkbox"/> | Heart valve replacement |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Arteriosclerosis | Y <input type="checkbox"/> N <input type="checkbox"/> | Hemophilia |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Asthma | Y <input type="checkbox"/> N <input type="checkbox"/> | Hepatitis |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Autoimmune disorders | Y <input type="checkbox"/> N <input type="checkbox"/> | Hypoglycemia |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Bleeding easily | Y <input type="checkbox"/> N <input type="checkbox"/> | Immune system disorder |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Bloating | Y <input type="checkbox"/> N <input type="checkbox"/> | Insomnia |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Blood pressure <input type="checkbox"/> High <input type="checkbox"/> Low | Y <input type="checkbox"/> N <input type="checkbox"/> | Intestinal disorders |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Bruising easily | Y <input type="checkbox"/> N <input type="checkbox"/> | Jaw joint surgery |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Cancer | Y <input type="checkbox"/> N <input type="checkbox"/> | Kidney problems |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Chemotherapy | Y <input type="checkbox"/> N <input type="checkbox"/> | Liver disease |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Chronic Bronchitis | Y <input type="checkbox"/> N <input type="checkbox"/> | Menstrual cramps |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Chronic fatigue | Y <input type="checkbox"/> N <input type="checkbox"/> | Multiple sclerosis |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Chronic mouth dryness | Y <input type="checkbox"/> N <input type="checkbox"/> | Muscle aches |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Cold hands & feet | Y <input type="checkbox"/> N <input type="checkbox"/> | Muscle shaking (tremors) |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Colitis | Y <input type="checkbox"/> N <input type="checkbox"/> | Muscle spasms or cramps |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Current pregnancy | Y <input type="checkbox"/> N <input type="checkbox"/> | Muscula dystrophy |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Depression | Y <input type="checkbox"/> N <input type="checkbox"/> | Nasal Stuffiness in the morning |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Diabetes | Y <input type="checkbox"/> N <input type="checkbox"/> | Nervousness |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Dizziness | Y <input type="checkbox"/> N <input type="checkbox"/> | Neuralgia |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Emphysema | Y <input type="checkbox"/> N <input type="checkbox"/> | Osteoporosis |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Epilepsy | Y <input type="checkbox"/> N <input type="checkbox"/> | Ovarian cysts |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Excessive thirst | Y <input type="checkbox"/> N <input type="checkbox"/> | Parkinson's disease |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Fainting spells | Y <input type="checkbox"/> N <input type="checkbox"/> | Poor circulation |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Fluid retention | Y <input type="checkbox"/> N <input type="checkbox"/> | Prior orthodontic treatment |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Frequent cough | Y <input type="checkbox"/> N <input type="checkbox"/> | Psychiatric treatment |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Frequent illnesses | Y <input type="checkbox"/> N <input type="checkbox"/> | Rheumatoid arthritis |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Frequent stressful situations | Y <input type="checkbox"/> N <input type="checkbox"/> | Rheumatic fever |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Glaucoma | Y <input type="checkbox"/> N <input type="checkbox"/> | Scarlet Fever |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Gout | Y <input type="checkbox"/> N <input type="checkbox"/> | Seizures |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Hay fever | Y <input type="checkbox"/> N <input type="checkbox"/> | Shortness of breath |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Headaches | Y <input type="checkbox"/> N <input type="checkbox"/> | Slow healing sores |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Hearing impairment | Y <input type="checkbox"/> N <input type="checkbox"/> | Sickle Cell Anemia |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Heart murmur | Y <input type="checkbox"/> N <input type="checkbox"/> | Sinus problems |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Injury to | Y <input type="checkbox"/> N <input type="checkbox"/> | Speech difficulties |
| <input type="checkbox"/> Face <input type="checkbox"/> Neck <input type="checkbox"/> Mouth <input type="checkbox"/> Teeth | | Y <input type="checkbox"/> N <input type="checkbox"/> | Stomach ulcers |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Extra pillows to help breathing at night | Y <input type="checkbox"/> N <input type="checkbox"/> | Stroke |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Tumors | Y <input type="checkbox"/> N <input type="checkbox"/> | Swelling of ankles |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Urinary Disorders | Y <input type="checkbox"/> N <input type="checkbox"/> | Tendency for frequent colds |
| Y <input type="checkbox"/> N <input type="checkbox"/> | Other Medical/Dental History _____ | Y <input type="checkbox"/> N <input type="checkbox"/> | Tuberculosis |



PLEASE LIST OTHER HEALTHCARE PRACTITIONERS SEEN IN THE LAST 9 MONTHS:

Practitioner	Specialty	Treatment & Approximate Date
<hr/>		
<hr/>		
<hr/>		

Do you take aspirin regularly YES NO Smoke tobacco YES NO

Has any close relative had a serious illness or condition? _____

Emotional or nervous disturbances? YES NO

If yes, please explain: _____

Patient Signature: _____ **Date:** _____