

# POLYVIOU FAMILY DENTAL HEALTH QUESTIONNAIRE

Name: \_\_\_\_\_ Date: \_\_\_\_\_

*Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Please fill out all spaces and check lines where necessary to complete the form.*

## PATIENT INFORMATION

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SEX: M \_\_\_\_\_ F \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home: \_\_\_\_\_ Work: \_\_\_\_\_ Emergency: \_\_\_\_\_

Email: \_\_\_\_\_ Social Security: \_\_\_\_\_

Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_

Name of Employer: \_\_\_\_\_ DR. Lic. #: \_\_\_\_\_

Responsible Party: \_\_\_\_\_ Responsible Party Soc. Sec: \_\_\_\_\_

Name of Spouse (If Applicable): \_\_\_\_\_ Soc. Sec: \_\_\_\_\_

## DENTAL INSURANCE INFORMATION

Date of Birth: \_\_\_\_\_

Employee Name: \_\_\_\_\_ DR. Lic. #: \_\_\_\_\_

Employee Social Security Number: \_\_\_\_\_ Name of Employer: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Name of Dental Insurance Company: \_\_\_\_\_ GRP #: \_\_\_\_\_

## 2<sup>ND</sup> DENTAL INSURANCE

Date of Birth: \_\_\_\_\_

Employee Name: \_\_\_\_\_ DR. Lic. #: \_\_\_\_\_

Employee Social Security Number: \_\_\_\_\_ Name of Employer: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Name of Dental Insurance Company: \_\_\_\_\_ GRP #: \_\_\_\_\_

**MEDICAL INSURANCE INFORMATION**

Date of Birth: \_\_\_\_\_

Employee Name: \_\_\_\_\_ Name of Employer: \_\_\_\_\_

Employee Social Security: \_\_\_\_\_ Name of Medical Insurance Company: \_\_\_\_\_

GRP #: \_\_\_\_\_

Who is responsible for your bill? \_\_\_\_\_

How will you be paying for today's services? Cash \_\_\_\_\_ Check \_\_\_\_\_ Visa \_\_\_\_\_ Mastercard \_\_\_\_\_ Exp. Date \_\_\_\_\_

Referred by: \_\_\_\_\_

\*Parents: It is our office policy that whichever parent brings the child in for treatment is responsible for payment.

**DENTAL INFORMATION**

Chief oral complain: \_\_\_\_\_

Date of last dental exam: \_\_\_\_\_ Cleaning: \_\_\_\_\_ X-Rays: \_\_\_\_\_

Any previous major dental treatment? Yes No When? \_\_\_\_\_

Do you have or use any of the following? (Please check for yes)

- Teeth sensitive to cold, heat, sweets or pressure? \_\_\_\_\_
- Bleeding Gums? (If yes, how long? \_\_\_\_\_) \_\_\_\_\_
- Food Impaction? \_\_\_\_\_
- Clenching or grinding? \_\_\_\_\_
- Burning of tongue? \_\_\_\_\_
- Swelling or lumps in the mouth? \_\_\_\_\_
- Frequent blisters on lips or mouth? \_\_\_\_\_
- Pain around ear? \_\_\_\_\_
- Unusual sounds in ear while eating? \_\_\_\_\_
- Unpleasant taste? \_\_\_\_\_
- Complications from extractions? \_\_\_\_\_
- Periodontal treatment? \_\_\_\_\_
- Orthodontic treatment? \_\_\_\_\_
- Cigarette, pipe or cigar smoking? \_\_\_\_\_
- Dental floss? \_\_\_\_\_
- Does your spouse complain that you snore loudly? \_\_\_\_\_

# MEDICAL HISTORY

Please check the line for any condition that you have had in the past or have now. (PARENT OR GUARDIAN: If you are completing this form for your child, please indicate your child's health status by checking the appropriate line.)

## 1. Cardiovascular

- Heart Failure: \_\_\_\_\_
- Heart disease or attack: \_\_\_\_\_
- Angina pectorals or chest pain: \_\_\_\_\_
- High blood pressure: \_\_\_\_\_
- Heart murmur: \_\_\_\_\_
- Mitral valve prolapse: \_\_\_\_\_
- Rheumatic fever: \_\_\_\_\_
- Congenital heart defect or lesion: \_\_\_\_\_
- Artificial heart valve: \_\_\_\_\_
- Arrhythmias: \_\_\_\_\_
- Heart pacemaker or defibrillator: \_\_\_\_\_
- Heart surgery or transplant: \_\_\_\_\_
- Other heart problems: \_\_\_\_\_
- Stroke: \_\_\_\_\_
- Aneurysm: \_\_\_\_\_

## 2. Hematologic

- Blood transfusion: \_\_\_\_\_
- Anemia: \_\_\_\_\_
- Hemophilia: \_\_\_\_\_
- Leukemia: \_\_\_\_\_
- Sickle cell (anemia disease): \_\_\_\_\_
- Tendency to bleed longer than normal: \_\_\_\_\_

## 3. Neural and Sensory

- Eye pain: \_\_\_\_\_
- Vision problems: \_\_\_\_\_
- Glaucoma or cataract: \_\_\_\_\_
- Earaches, ringing in ears: \_\_\_\_\_
- Hearing loss: \_\_\_\_\_
- Severe headaches: \_\_\_\_\_
- Fainting or dizzy spells: \_\_\_\_\_
- Epilepsy, seizures, or convulsions: \_\_\_\_\_
- Nervousness: \_\_\_\_\_
- Psychiatric treatment: \_\_\_\_\_

## 4. Gastrointestinal

- Stomach or intestinal ulcers: \_\_\_\_\_
- Gastritis: \_\_\_\_\_
- Colitis: \_\_\_\_\_
- Persistent diarrhea: \_\_\_\_\_
- Hepatitis: \_\_\_\_\_
- Liver disease: \_\_\_\_\_
- Yellow jaundice: \_\_\_\_\_
- Cirrhosis: \_\_\_\_\_

## 5. Respiratory

- Hay fever: \_\_\_\_\_
- Sinus trouble: \_\_\_\_\_
- Allergies or hives: \_\_\_\_\_
- Asthma: \_\_\_\_\_
- Chronic cough: \_\_\_\_\_
- Emphysema: \_\_\_\_\_
- Tuberculosis (TB): \_\_\_\_\_
- Breathing difficulties: \_\_\_\_\_

## 6. Dermal Mucocutaneous Musculoskeletal

- Allergy to latex (rubber): \_\_\_\_\_
- Skin rash: \_\_\_\_\_
- Dark mole(s)(recent changes in appearance): \_\_\_\_\_
- Night sweats: \_\_\_\_\_
- Sore muscles: \_\_\_\_\_
- Stiff joints: \_\_\_\_\_
- Arthritis: \_\_\_\_\_
- Artificial joint: \_\_\_\_\_
- Fever blister: \_\_\_\_\_
- Mouth ulcers or canker sores: \_\_\_\_\_
- Colored or discolored areas in mouth: \_\_\_\_\_

## 7. Endocrine

- Diabetes: \_\_\_\_\_
- Thyroid disease: \_\_\_\_\_

## 8. Urinary – Sexually Transmitted

- Urinate frequently: \_\_\_\_\_
- Kidney, bladder problem: \_\_\_\_\_
- Sexually transmitted disease (syphilis, gonorrhea, Chlamydia, genital herpes): \_\_\_\_\_
- HIV-positive: \_\_\_\_\_

## 9. Other Conditions

- Frequent sore throats: \_\_\_\_\_
- Enlarged lymph node or "gland": \_\_\_\_\_
- Use tobacco: \_\_\_\_\_
- Use alcohol: \_\_\_\_\_
- Drug addiction: \_\_\_\_\_
- Tumor or cancer: \_\_\_\_\_
- X-Ray or cobalt treatment: \_\_\_\_\_
- Chemotherapy: \_\_\_\_\_
- Disease, problem or condition not listed: \_\_\_\_\_  
If yes, list below

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10. Are you currently under the care of a physician? Yes No

Physician Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Last Appointment: \_\_\_\_\_

For what? \_\_\_\_\_

11. Are you taking (or supposed to be taking any medicine, drugs, or pills of any kind? Yes No

12. Have you taken cortisone or other steroids in the past 12 months? Yes No

13. Do you have reactions or allergies to drugs or medicines? Yes No

14. Have you had a reaction to dental or general anesthesia? Yes No

15. Have you ever had an operation or surgery? Yes No

Describe the problem and any complications \_\_\_\_\_

16. Have you ever been hospitalized? Yes No

17. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or feeling tired? Yes No

18. Do your ankles swell during the day? Yes No

19. Do you sleep on two or more pillows? Yes No

20. Have you unintentionally lost or gained more than 10 points in the past year? Yes No

21. Are you on a special diet? Yes No

22. Does your occupation bring you into contact with blood, blood products, or needles? Yes No

23. WOMEN: Are you pregnant? Yes No

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, abnormal laboratory test, or medicine change, I will inform the dentist at the next appointment without fail.

Date: \_\_\_\_\_ Patient, Parent or Guardian Signature \_\_\_\_\_

Height: \_\_\_\_\_; Weight: \_\_\_\_\_; BP: \_\_\_\_\_; Pulse: \_\_\_\_\_; Resp: \_\_\_\_\_; Temp: \_\_\_\_\_;

For additional information, write on additional pieces of paper