New Teeth By Pro™

QUESTIONNAIRE

Name:_____ **Date:**_____

ORAL HABITS

Y - N

Do you:

- ☐ ☐ Smoke cigarettes, or chew tobacco or use snuff ?
- ☐ ☐ Drink alcohol?
- ☐ ☐ Drink sugary drinks frequently?
- ☐ ☐ Currently use any dental whitening product?

HEALTH HISTORY

Physician's Name:_____

Phone #:_____

CARDIOVASCULAR

Yes - No

Do you have or ever had :

1. ☐ ☐ Heart trouble? or prolapsed mitral valve?
2. ☐ ☐ ☐ High or ☐ Low blood pressure?
3. ☐ ☐ A heart murmur of any cause?
4. ☐ ☐ Do you take antibiotics before dental treatment ?
5. ☐ ☐ An stroke?

RESPIRATORY

Do you have or ever had :

1. ☐ ☐ Asthma, hay-fever, sinusitis and/or sore throats ?
2. ☐ ☐ Chronic cough or cough up blood?
3. ☐ ☐ Bronchitis or emphysema?

NEUROLOGIC AND ENDOCRINE

1. ☐ ☐ Have you ever been under psychiatric care ?
2. ☐ ☐ Do you have numbness or tingling anywhere?
3. ☐ ☐ Do you have diabetes?
4. ☐ ☐ Do you have thyroid issues/ take thyroid tablets?

G-I AND G-U

1. ☐ ☐ Have you had jaundice, liver trouble or hepatitis?
2. ☐ ☐ Do you have chronic acid reflux or vomiting?
3. ☐ ☐ Have you ever had kidney or bladder trouble?
4. ☐ ☐ Have you had sexually transmitted diseases ? (syphilis, gonorrhea, genital herpes, HIV/AIDS)

HEMATOLOGY AND IMMUNOLOGY

1. ☐ ☐ Have you had anemia ? Do you bruise /bleed easily ?
2. ☐ ☐ Do you have leukemia?
3. ☐ ☐ Are you sensitive or allergic to any medication? (penicillin, sulfa drugs, aspirin, etc.)
4. ☐ ☐ Do you have defective immune system?

MUSC-SKEL

Yes - No

1. ☐ ☐ Do you have arthritis? back problems?
2. ☐ ☐ Do you have osteoporosis? Do you take medications?

IMPLANTS

Do you have:

1. ☐ ☐ An artificial heart valve?
2. ☐ ☐ A pacemaker or defibrillator?
3. ☐ ☐ Any other implant or prosthetic joint ?

SURGERY-ANESTHESIA

Have you ever had:

1. ☐ ☐ An operation?, Anesthesia ? Local— General—
2. ☐ ☐ A cancer or a tumor?
3. ☐ ☐ Radiation therapy or chemotherapy?
4. ☐ ☐ An organ/ bone marrow transplant?
5. ☐ ☐ Are you an active/ recovering substance abuser?

FACIAL PAIN

1. ☐ ☐ Do you have a history of head or neck injury?
2. ☐ ☐ Have you ever had severe pain of the face /head?
3. ☐ ☐ Do you suffer from headache, eye pain or migraine?
4. ☐ ☐ Do you have ear pain or pain in front of your ears?
5. ☐ ☐ Does anything hurt when you chew?
6. ☐ ☐ Does the pain interfere with your work activities?

FOR WOMEN ONLY

1. ☐ ☐ Are you taking birth control pills?
2. ☐ ☐ Are you pregnant? Expected delivery date _____
3. ☐ ☐ Are you breast feeding?

I verify that, to the best of my knowledge, the above information is correct.

_____

Patient's Signature

DO NOT WRITE BELOW THIS LINE

_____

NOTES