Eric Batterton DDS

Today's Date:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential.

Name: **DOB:**

What concerns do you have about your teeth or smile?	**Immediate:**	**Long Term:**

Are you apprehensive about dental treatment?	☐ Y ☐ N	**When was your last dental visit?**	_____/_____/_____
Do you have a sore or hoarse throat?	☐ Y ☐ N	**Do you have any sores or lumps in your mouth?**	☐ Y ☐ N

MEDICAL HISTORY

Are you in good health?	☐ Y ☐ N _____
Has your health changed in the past year	☐ Y ☐ N _____
Are you currently being treated by a physician for any condition?	☐ Y ☐ N _____

When was your last physical examination? _____/_____/_____

Have you had a serious illness or been hospitalized in the past 5 years? ☐ Y ☐ N _____

Medications including prescriptions, over the counter medications and natural/herbal supplements:

Name:	For:	Dose:

MEDICAL ISSUES

Check if you have, or have had, any of the following diseases, problems or conditions:

HAVE	HAD		HAVE	HAD		HAVE	HAD	
☐	☐	Infective Endocarditis	☐	☐	Sinus problems	☐	☐	Abnormal bleeding
☐	☐	Damaged or artificial heart valves	☐	☐	Emphysema, Bronchitis or other respiratory problems	☐	☐	Blood disorder such as anemia
☐	☐	Congenital Heart Defects	☐	☐	Seasonal, pet or similar allergies	☐		Organ transplant
☐	☐	High Blood Pressure	☐	☐	Asthma	☐	☐	Arthritis or swollen joints
☐	☐	Heart Attack	☐	☐	Tuberculosis	☐		Surgically replaced joints
☐	☐	Cardiovascular Disease (Arteriosclerosis)	☐	☐	Stomach ulcers or colitis	☐	☐	Fainting or seizure disorders
☐	☐	Chest pain on exertion	☐	☐	Kidney trouble	☐	☐	Immune system disorders
☐	☐	Shortness of breath from mild exertion or when laying down	☐	☐	Thyroid problems	☐	☐	Sexually transmitted disease
☐	☐	Swollen ankles	☐	☐	Diabetes	☐	☐	Hepatitis, jaundice or liver disease
☐	☐	Cardiac pacemaker or defibrillator	☐	☐	Relative with diabetes	☐		AIDS or HIV
☐	☐	Cancer	Please specify:					
☐	☐	Treatment for a tumor or growth?	Treatment used:					
☐	☐	Mental health disorders	Please specify:					

SEE NEXT PAGE

NAME:_____**DOB:**_____

ALLERGIES	
Are you allergic to latex?	☐ Y ☐ N
Are you allergic to any medicine or drug?	☐ Y ☐ N
*ex- penicillin, local anesthetics, sulfas, aspirin, codeine	

WOMEN ONLY	
Are you pregnant or nursing?	☐ Y ☐ N
Are you taking birth control pills?	☐ Y ☐ N

BISPHOSPHONATES			
New information has shown that certain bone strengthening medications may affect the mouth. It is very important that we know if you are **TAKING OR HAVE TAKEN** any of the following medications:			
Alendronate (Fosamax)	☐ Y ☐ N	Residronate (Actonel)	☐ Y ☐ N
Atelvia (risedronate sodium)	☐ Y ☐ N	Ibandronate (Boniva)	☐ Y ☐ N
Reclast (zoledronic acid injection)	☐ Y ☐ N		
If yes to the above question, how long ago did you take the medication?_____How long did you take the medication?_____			
Some other bone strengthening medications are given intravenously in the hospital for certain types of cancer (metastatic deposits from multiple myeloma or breast, prostate, renal or lung cancers.) Have you ever been given either of the following medications intravenously?			
Pamidronate (Aredia)	☐ Y ☐ N	Zoledronate (Zometa)	☐ Y ☐ N

TMJ	
Have you ever been diagnosed with a problem with either jaw joint?	☐ Y ☐ N
Does your jaw click, pop or make noise when you open or close? If not now, in the past?	☐ Y ☐ N
Do you have pain or tenderness in your jaw when you open, close or chew?	☐ Y ☐ N
Has your jaw ever locked open or closed?	☐ Y ☐ N
Do you have frequent headaches? If so, how often and where?	☐ Y ☐ N
Do you clench or grind your teeth, or been told that you do?	☐ Y ☐ N
Do you have a history of trauma to your chin or jaw?	☐ Y ☐ N
Do you or have you ever worn a night guard?	☐ Y ☐ N

SLEEP APNEA (STOP BANG)		
Do you **s**nore loudly (louder than talking/ can you be heard through closed doors?) ☐ Y ☐ N		
Do you often feel **t**ired, fatigues or sleepy during daytime? ☐ Y ☐ N		
Has anyone **o**bserved your breathing stop during sleep? ☐ Y ☐ N		
Do you have or are you being treated for high blood **p**ressure? ☐ Y ☐ N		
BMI -Please list your weight_____lbs Please list your height_____'_____"		
**provider calculation formula – lbs/inches^2 x 703 must be ≥ 35* ☐ Y ☐ N		
Are you over 50 years of **a**ge? ☐ Y ☐ N		
Is your **n**eck greater than 17 inches for a male or 16 inches for a female? ☐ Y ☐ N		
Are you male? (**g**ender) ☐ Y ☐ N		
Yes for 0-2 questions is low risk	Yes for 3-4 questions is intermediate risk	Yes for 5-8 questions is high risk