



E. Griffin Cole, DDS

Personal History

(information will be held in strict confidence)

Date _____

Name _____

Date of birth _____ Gender: M F

Marital Status S M Spouse's Name _____

SS # _____

Address _____ City, State, Zip _____

Home Phone _____ Work Phone (or cellular) _____

Fax _____ E-mail Address _____

Employer _____ Employer's Address _____

Person to contact in event of emergency _____

REFERRED BY: _____

Health Questionnaire

Yes / No Are you in good health?
In not, explain briefly _____

Name of health care practitioner _____
Date of last physical examination _____

Yes / No Are you currently seeing a health care professional?
For what reason? _____

Yes / No Have you had any serious illness or operations?
If so, explain briefly _____

Yes / No Are you taking any medications? (including diet pills)
If so, please list _____

Dental History continued...

Do you have (or have you ever experienced) the following?

- | | | | |
|-------|-------------------------------|-------|----------------------------------|
| Y / N | Bleeding, sore gums | Y / N | Loose teeth |
| Y / N | Unpleasant taste / bad breath | Y / N | Sensitive to hot |
| Y / N | Burning tongue / lips | Y / N | Sensitive to cold |
| Y / N | Frequent Blisters | Y / N | Sensitive to sweets |
| Y / N | Swelling / Lumps in mouth | Y / N | Biting sensitivity |
| Y / N | Ortho treatment (braces) | Y / N | Food impaction |
| Y / N | Biting cheeks / lips | Y / N | Shifting in bite |
| Y / N | Clicking / Popping jaw | Y / N | Clenching / Grinding when? _____ |

Y / N Are you having any discomfort at this time? If yes, explain _____

Y / N Have you ever had any serious problems associated with previous dentistry?
Explain _____

Y / N These are the things that are important to me regarding my dental health:

Signature of patient _____ *Date* _____

Signature of doctor _____ *Date* _____

Medical History

Are you allergic OR have you reacted adversely to:

- Y / N Aspirin
Y / N Local anesthetics
Y / N Penicillin or other antibiotic _____
Y / N Sulfa drugs
Y / N Barbiturates, sedatives (or sleeping pills)
Y / N Iodine
Y / N Codeine or other analgesic _____
Y / N OTHER _____

Do you have any of the following diseases or conditions?

- | | |
|---|--|
| Y / N Heart murmur | Y / N Mitral Valve Prolapse |
| Y / N Congenital heart lesions | Y / N Cardiovascular disease (heart trouble) |
| Y / N Rheumatic fever (or heart disease) | Y / N Do you have a pace maker? |
| Y / N High blood pressure | Y / N Low blood pressure |
| Y / N Are you on a blood thinner? | Y / N Abnormal bleeding from a cut |
| Y / N Joint replacement or surgery | Y / N Stroke, atherosclerosis |
| Y / N Diabetes (do you take insulin? Y/N) | Y / N Hepatitis, liver disease |
| Y / N Kidney problems | Y / N Anemia |
| Y / N Arthritis | Y / N Inflammatory rheumatism (joint pain) |
| Y / N Tuberculosis | Y / N Asthma (or hay fever) |
| Y / N Hives (or skin rash) | Y / N Environmental sensitivities |
| Y / N Seizures (or fainting spells) | Y / N Stomach ulcers (or other ulcers) |
| Y / N Do you have a persistent cough? | Y / N Hearing / Vision loss |
| Y / N HIV positive | Y / N Sexually transmitted disease |
| Y / N High Cholesterol | Y / N Latex sensitivity |
| Y / N Other conditions not listed _____ | |

Dental Questionnaire

Accurate answers to the following questions will allow us to treat you on a more individual basis, providing the appropriate care for your particular needs. Your answers will be considered confidential.

Date of most recent dental visit _____

Does dental treatment make you nervous? No / Somewhat / Extremely

My mouth is: very comfortable / moderately comfortable / uncomfortable

I think the appearance of my mouth is: excellent / satisfactory / unsatisfactory

Do you use the following? Toothbrush / Dental Floss / Oral irrigator / Other

How often do you brush? _____ Do you use a soft brush? Yes / No

Have you ever been treated for periodontal disease (gum disease)? Yes / No

