Ewa Awad D.D.S.
Cosmetic and Family Dentistry

MEDICAL HISTORY QUESTIONNAIRE

Today's Date:		Date of Birth:	
Name:		SS#:	
Address:		Employer:	
		Occupation:	
		Primary Care Doctor Name:	
Email:		Primary Care Doctor Phone:	
Cell Phone:		Previous Dentist Name:	
Home Phone:		Previous Dentist Phone:	
Work Phone:		Emergency Contact:	

INSURANCE INFORMATION

Name of **Primary Dental** Insurance:		Name of **Secondary Dental** Insurance:	
Primary Dental Insurance ID#:		**Secondary Dental** Insurance ID#:	
Primary Dental Group#:		**Secondary Dental** Group#:	
Primary Dental Insurance Holder:		**Secondary Dental** Insurance Holder:	
Primary Dental Ins. Holder SS#:		**Secondary Dental** Ins. Holder SS#:	
Primary Dental Ins. Holder DOB:		**Secondary Dental** Ins. Holder DOB:	

Whom may we thank for referring you to our practice? ☐Patient ☐Internet Search ☐Insurance ☐Mailer ☐Referral Other:

Would you like your appointment confirmation by: ☐Phone ☐Text ☐Email ☐All of the Above

DENTAL HEALTH

How important is your dental health to you? *(Not important)* ☐1 ☐2 ☐3 ☐4 ☐5 *(Extremely important)*

Where would you rate your current dental health: ☐Poor ☐Fair ☐Good ☐Excellent

Are you satisfied with the appearance of your smile? ☐ Y ☐N

Are you interested in Invisalign (invisible braces)? ☐ Y ☐N

Are you interested in teeth whitening? ☐ Y ☐N

If you have missing teeth, are you interested in replacing the spaces? ☐ Y ☐N

Y	N	**Have you noticed any of the following:**	Y	N	**Are you allergic to or had an adverse reaction to any of the following:**
☐	☐	Sensitivity to hot or cold?	☐	☐	Penicillin

26 Madison Avenue, Morristown, NJ, 07960 Tel:(973)500-2555 Fax:(973)500-6007
www.dentexsmilestudio.com

Dentex Smile Studio

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☐	☐	Sensitivity to sweets?	☐	☐	Latex
☐	☐	Sensitivity to biting or chewing?	☐	☐	Aspirin
☐	☐	Any mouth odor or bad taste?	☐	☐	Codeine
☐	☐	Cold sores, blisters, or any other oral lesions?	☐	☐	Sulfa drugs Other:

Y	N	**Have you ever had:**	Y	N	**Have you ever experienced:**
☐	☐	Orthodontic treatment (braces)?	☐	☐	Clicking or popping in the jaw?
☐	☐	Oral surgery?	☐	☐	Pain (ear or side of face)?
☐	☐	Periodontal (gums) treatment?	☐	☐	Difficulty of opening or closing your mouth?
☐	☐	A bite plate, splint, or a mouth guard?	☐	☐	Headaches, neck aches, or shoulder aches?
☐	☐	A serious injury to the mouth or head?	☐	☐	Sore muscles around the face?

Y	N	**Do you:**	Y	N	**Are you:**
☐	☐	Clench or grind your teeth?	☐	☐	Committed to keeping all of your teeth?
☐	☐	Bite your lips or cheeks regularly?	☐	☐	Nervous about having dental treatment?
☐	☐	Mouth breath while awake or asleep?	☐	☐	Used to pre-medicating for your dental appointments?

Y	N	**Periodontal (gums) tissue concerns:**	
☐	☐	Do your gums bleed or hurt?	How often do you see your hygienist? Every ☐12mo ☐6mo ☐3mo
☐	☐	Have you noticed any loose teeth or changes in your bite?	How often do you brush your teeth? ☐1/day ☐2/day ☐rarely ☐never
☐	☐	Does food tend to get stuck in between teeth?	How often do you floss? ☐Daily ☐2-3 times/wk ☐rarely ☐never
☐	☐	Do you currently use an electric toothbrush?	What other dental aids do you use? (Waterpik, Tongue Scraper, proxy)

Y	N	**PATIENT SOCIAL HISTORY**
☐	☐	Ever been exposed or infected with Gonorrhea, Syphilis, Herpes, Hepatitis, HIV (AIDS)?
☐	☐	Do you use tobacco products? If yes, type, amount and how long?
☐	☐	Do you drink alcohol? If yes, type, amount and how long?
☐	☐	Do you use recreational drugs? If yes, type, amount, how long?

Y	N	**GENERAL HEALTH**
☐	☐	Any changes in your general health in the past year? If Yes, please explain:
☐	☐	Are you under the care of a physician? If Yes, please explain:
☐	☐	Any illness or hospitalization in the past 5 years? If Yes, please explain:

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Y	N		Y	N
HAVE YOU EXPERIENCED:				
☐	☐	Chest pain (angina)?	☐	☐
☐	☐	Swollen Ankles?	☐	☐
☐	☐	Shortness of breath?	☐	☐
☐	☐	Recent weight loss, fever, or night sweats?	☐	☐
☐	☐	Persistent cough, coughing up blood?	☐	☐
☐	☐	Bleeding problems, bruising easily?	☐	☐
☐	☐	Sinus problems	☐	☐
☐	☐	Difficulty swallowing	☐	☐
☐	☐	Diarrhea, constipation, blood in stool?	☐	☐
☐	☐	Frequent vomiting, nausea?	☐	☐
☐	☐	Difficulty urinating, blood in urine?	☐	☐
DO YOU HAVE OR HAVE YOU HAD:				
☐	☐	Heart attack or stroke?	☐	☐
☐	☐	Heart murmurs?	☐	☐
☐	☐	Rheumatic fever?	☐	☐
☐	☐	High blood pressure?	☐	☐
☐	☐	Asthma, TB, emphysema, other lung disease?	☐	☐
☐	☐	Hepatitis, other liver disease?	☐	☐
☐	☐	Stomach problems, ulcers?	☐	☐
☐	☐	Psychiatric care?	☐	☐
☐	☐	Radiation treatments?	☐	☐
☐	☐	Chemotherapy?	☐	☐
☐	☐	Prosthetic heart valve?	☐	☐
WOMEN ONLY:				
☐	☐	Are you pregnant/trying to get pregnant/nursing?	☐	☐
☐	☐	Are you taking birth control pills?	☐	☐
ALL PATIENTS:				
Please list any other diseases or medical problems NOT listed on this form?				

List of Medications (Prescribed, over the counter & natural remedies)	Condition Medication is Treating

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