MEDICAL/DENTAL QUESTIONAIRE - pg 1 of 2
Douglas J. Hinterman, DDS

Hinterman Dental
COSMETIC
& FAMILY
DENTISTRY

DATE:______________________

The following information will make it possible for us to be more successful and thorough in your treatment. Your answers are for our records only and will be considered to be confidential.

Patient name ____ Age ________________________

Name of Physician ________________________________ Date of last physical exam ________________________

MEDICAL HISTORY

What is your estimation of your general health? Good Fair Poor

Please circle yes or no and explain where appropriate:

Yes No Are you now under the regular care of a physician?
If so, what for? ____

Yes No Have you had any major operations, hospitalizations or illnesses?
If so, what for? ____

Yes No Are you taking any pills, medications or drugs?
If so, what medication and what for? ____

Yes No Do you have any allergies and are you sensitive to any drugs (i.e. Codeine, novocaine, latex, ect.)
If so, what for? ____

Yes No Are you subject to fainting, dizziness, nervous disorders, convulsions or epilepsy?
If so, what for? ____

Yes No Do you use tobacco products?

Yes No Do you drink alcohol?

Have you ever had, or do you have, any of the following: (CIRCLE)

Rheumatic fever
Heart murmur
Heart attack
Angina pectoris
Stroke
Hepatitis or liver disease
Asthma
High or low blood pressure
Diabetes
Kidney disease
Seizure disorder
Glaucoma
Arthritis
Thyroid disease
Alcohol/Drug dependency
Swelling or hands or feet
Numbness of face or mouth
Neck or back problems
Stomach or intestinal disease
Tumors or growths
Blood transfusion
Anemia
Blood disorder
Tuberculosis
Venereal disease
AIDS or HIV positive
Artificial joints/implants/pacemaker
X-ray or radiation therapy
Chemotherapy (cancer, leukemia)
Jaw problems (TMJ)
Mental or psychological condition
Condition requiring cortisone or other steroids

Yes No Has a member of your family had tuberculosis, diabetes, heart disease, allergies, bleeding Problems or cancer? If yes, who? and please explain.

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WOMEN ONLY:

Yes No Are you Pregnant?

Yes No Nursing?

Yes No Taking birth control pills?

Yes No Do yo have any menstrual problems?

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Yes No Have you had any serious trouble or a bad experience associated with any previous dental treatment?

If yes, explain____

Have you ever had

- ______ Orthodontic treatment (braces)
- ______ Oral Surgery (extractions, ect.)
- ______ Periodontal treatment (gum disease)
- ______ Endodontic treatment (root canals)
- ______ Prosthodontic treatment (crowns, bridges, partial dentures, dentures, implants)
- ______ Your teeth ground or bite adjusted

Yes No Do you bleed excessively after a cut, wound, or surgery?

Yes No Have you had excessive pain or swelling after oral surgery?

Yes No Are you dissatisfied with your chewing ability?

Yes No Have you noticed any loosening of your teeth?

Yes No Do you clench or grind your teeth?

Yes No Do your gums bleed?

Yes No Do you have a bad taste in your mouth?

Yes No Does food pack between your teeth?

Yes No Are any of your teeth sensitive to cold or sweets?

Yes No Have your teeth been cleaned recently?

Yes No Do you have any disease, condition, or problem not listed above that you think I should know about?

If yes explain ____

What are your main concerns regarding your mouth/teeth/smile?

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I have completed this medical/dental questionnaire to the best of my knowledge. If I ever have any changes, I will inform the doctor.

Patient Signature:________________________ Date: ____________________

Reviewed by Dr. ________________________ Date: ____________________

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