Dr. Chopra Dental Clinic
We Design your Smile

Patient Information

Patient

Spouse

Name

Date

Address

Home Phone Business Phone Cell Phone

DOB

Email:

Emergency Contact Phone Relationship

Medical History

Allergic to

Aspirin AIDS/ HIV Epilepsy Rheumatic Fever Barbituates/Sleeping Pills Anemia/ Leukemia Fainting Spells/ Seizures Rheumatic Heart Codeine/Other Narcotics Ankles Swell Fever Blisters/ Herpes Shortness of Breath
Iodine Anorexia / Bulimia Frequent Headaches Stroke
Latex Rubber Arthritis Gall Bladder Trouble Sinus Trouble
Local Anesthetics Asthma /Hay Fever Glaucoma Skin Problem
Metals Blood Clotting Problems Heart Attack/ Chest Pain Stomach Ulcers
Epinephrine Blood Transfusion Heart Disease Thyroid Problems
Penicillin Hepatitis / Jaundice High Blood Pressure Tuberculosis
Sulfa Drugs Bronchitis Hives / Skin Rash Unusual Weight Loss
Frequently Cancer / Tumor or Growth Joint Replacement Urinate frequently
Erythromycin Cardiac Pacemaker Kidney / Bladder Trouble

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Other

Tetracycline Chest Pain on Exertion Liver Disease ECG last two years Other Color Blindness Low Blood Pressure Sleep on More Than Contact Lenses Lymphatic Problems 2 Pillows

Check if Applicable Damaged Heart Valve Mental Health Nitroglycerin Use No Change Since Last Time Diabetes Mitral Valve Replacement No Known Concerns or Issues Emphysema Need to Pre-medicate Alcohol/ Drug Abuse Environmental Allergies Pneumonia

Medical Questionnaire

Physician Phone

Specialist

Phone

Are you currently under care of Physician/Specialist
If Yes, what is the condition that is being treated
Have you had any serious illness, operation, or been hospitalized within the past 5 years
If Yes what is the illness or problem?
Are you currently taking medication?

If Yes, Please list all medication and doses
Do you use alcoholic beverages Do you smoke

Women Only
Are you pregnant Are you nursing Do you use fertility Drugs

Dental Questionnaire

Date of your last dental exam
Date of you last cleaning
Date of your last full series of x-rays
Do your Gums Bleed when flossing?
Are your teeth sensitive to hot, cold, or sweets?
Do you get frequent fever blisters, mouth ulcers, or sores on your lips?

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Have you ever had burning of the tongue or cracking of the corners of your mouth?
Do you chew/ smoke tobacco in any form?
Do you notice popping, clicking or soreness of the jaws?
Have you had orthodontic treatment?
Have you ever been told you have Gum Disease?
Have you ever been treated for Periodontal (Gum) Disease?
Do you have any loose teeth?
Are you missing any teeth?
Do you have any shifting of your teeth?
Do you wear dentures or partials?
Are you happy with your dentures/partials?
Are you interested in Dental Implants?
Do you have sensitivity in any teeth?
Do you have Gum Recession?
Are you happy with your smile?
Do you regularly use dental floss?
Do you have unpleasant taste or odor in your mouth?
Do you want to learn to control your dental disease and retain your teeth?

Does food catch between your teeth?
Are you a mouth breat her?
Additional comments?