# CONFIDENTIAL PATIENT QUESTIONNAIRE

spaDENTAL

Date of Completion:

First Names: Mr/Mrs/Miss/Ms/Dr:

Last Name: I prefer to be called:

Email address: Birthdate: / /

Address:

Phone Numbers – Home: Mobile: Work:

Did anyone refer you to SpaDental? If so, who:

## Medical History

| DO YOU HAVE or HAVE YOU EVER HAD: | YES | NO |
|---|---|---|
| 1. An allergic reaction to: | ☐ | ☐ |
| aspirin, ibuprofen, acetaminophen, codeine | ☐ | ☐ |
| penicillin | ☐ | ☐ |
| erythromycin | ☐ | ☐ |
| tetracycline | ☐ | ☐ |
| sulfur | ☐ | ☐ |
| local anaesthetic | ☐ | ☐ |
| fluoride | ☐ | ☐ |
| metals (nickel, gold, silver, _____ ) | ☐ | ☐ |
| latex | ☐ | ☐ |
| other | ☐ | ☐ |
| 2. Heart problems, or cardiac stent within last six months | ☐ | ☐ |
| 3. History of infective endocarditis | ☐ | ☐ |
| 4. Artificial heart valve, repaired heart defect (PFO) | ☐ | ☐ |
| 5. Pacemaker or implantable defibrillator | ☐ | ☐ |
| 6. Artificial prosthesis (heart valve or joints) | ☐ | ☐ |
| 7. Rheumatic or scarlet fever | ☐ | ☐ |
| 8. High or low blood pressure | ☐ | ☐ |
| 9. A stroke | ☐ | ☐ |
| 10. Anaemia | ☐ | ☐ |
| 11. Prolonged bleeding due to a slight cut (INR > 3.5) | ☐ | ☐ |
| 12. Emphysema, sarcoidosis | ☐ | ☐ |
| 13. Tuberculosis | ☐ | ☐ |
| 14. Asthma | ☐ | ☐ |
| 15. Breathing or sleep problems (i.e. snoring, sinus) | ☐ | ☐ |
| 16. Kidney disease | ☐ | ☐ |
| 17. Liver disease | ☐ | ☐ |
| 18. Jaundice | ☐ | ☐ |
| 19. Thyroid, parathyroid disease, or calcium deficiency | ☐ | ☐ |
| 20. Hormone deficiency | ☐ | ☐ |
| 21. High cholesterol or taking statin drugs | ☐ | ☐ |
| 22. Diabetes | ☐ | ☐ |

| | YES | NO |
|---|---|---|
| 23. Stomach or duodenal ulcer | ☐ | ☐ |
| 24. Digestive disorder (i.e. gastric reflux) | ☐ | ☐ |
| 25. Osteoporosis/osteopenia (i.e. taking bisphosphonates) | ☐ | ☐ |
| 26. Arthritis | ☐ | ☐ |
| 27. Glaucoma | ☐ | ☐ |
| 28. Contact lenses | ☐ | ☐ |
| 29. Head or neck injuries | ☐ | ☐ |
| 30. Epilepsy, convulsions (seizures) | ☐ | ☐ |
| 31. Neurologic problems (attention deficit disorder) | ☐ | ☐ |
| 32. Viral infections and cold sores | ☐ | ☐ |
| 33. Any lumps or swelling in the mouth | ☐ | ☐ |
| 34. Hives, skin rash, hay fever | ☐ | ☐ |
| 35. Hepatitis (type ___ ) | ☐ | ☐ |
| 36. HIV / AIDS | ☐ | ☐ |
| 37. Tumor, abnormal growth | ☐ | ☐ |
| 38. Radiation therapy | ☐ | ☐ |
| 39. Chemotherapy | ☐ | ☐ |
| 40. Psychiatric treatment | ☐ | ☐ |
| 41. Antidepressant medication | ☐ | ☐ |
| **ARE YOU:** | | |
| 42. Aware of a change in your health (i.e. fever, new cough) | ☐ | ☐ |
| 43. Taking dietary supplements | ☐ | ☐ |
| 44. Often exhausted or fatigued | ☐ | ☐ |
| 45. Experiencing frequent headaches (if YES, go to page 2) | ☐ | ☐ |
| 46. A smoker, smoked previously or use smokeless tobacco | ☐ | ☐ |
| 47. Often unhappy or depressed | ☐ | ☐ |
| 48. FEMALE - taking birth control pills | ☐ | ☐ |
| 49. FEMALE - pregnant | ☐ | ☐ |
| 50. MALE - prostate disorders | ☐ | ☐ |

Have you been hospitalised or under the care of a medical doctor during the last five years? YES / NO

If yes, please list Doctor's name(s): Phone:

Phone:

**Please list all the medications you are currently taking:** **Reason for taking:**

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## Dental History

**PLEASE ANSWER YES OR NO TO THE FOLLOWING:** YES NO

### PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____]
2. Have you ever had an upsetting dental experience?
   If yes, please describe:
3. Have you ever had complications from past dental treatment?
4. Have you ever had trouble getting numb or had any reactions to local anaesthetic?
5. Have you ever had braces, orthodontic treatment or had your bite adjusted?
6. Have you had any teeth removed?

### SMILE CHARACTERISTICS

7. Is there anything about the appearance of your teeth that you would like to change?
8. Have you ever whitened (bleached) your teeth?
9. Have you felt uncomfortable or self conscious about the appearance of your teeth?
10. Have you been disappointed with the appearance of previous dental work?

### BITE AND JAW JOINT

11. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)
12. Do you / would you have any problems chewing gum?
13. Do you / would you have any problems chewing bagels, baguettes , protein bars, or other hard foods?
14. Have your teeth changed in the last 5 years, become shorter, thinner or worn?
15. Are your teeth crowding or developing spaces?
16. Do you have more than one bite and/or squeeze to make your teeth fit together?
17. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?
18. Do you clench your teeth in the daytime or make them sore?
19. Do you have any problems with sleep or wake up with an awareness of your teeth?
20. Do you wear or have you ever worn a bite appliance?

### TOOTH STRUCTURE

21. Have you had any cavities within the past 3 years?
22. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?
23. Do you feel or notice any holes (i.e. pitting, craters) on the biting surfaces of your teeth?
24. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?
25. Do you have any grooves or notches on your teeth near the gum line?
26. Have you ever had broken or chipped teeth, or had a toothache or cracked filling?
27. Do you frequently get food caught between any teeth?

### GUM AND BONE

28. Do your gums bleed or are they painful when brushing or flossing?
29. Have you ever been treated for gum disease or been told you have lost bone around your teeth?
30. Have you ever noticed an unpleasant taste or odour in your mouth?
31. Is there anyone with a history of periodontal disease in your family?
32. Have you ever experienced gum recession?
33. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?
34. Have you experienced a burning sensation in your mouth?

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## Concerns

**WHAT IS THE MAIN CONCERN FOR WHICH YOU ARE SEEKING TREATMENT?**

Note: Please identify your main concern as #1, and place a tick next to all other concerns

| | Recent | Chronic (6mth+) | | Recent | Chronic (6mth+) |
|---|---|---|---|---|---|
| ____ Dental Examination | ☐ | ☐ | ____ Dizziness | ☐ | ☐ |
| ____ Broken teeth | ☐ | ☐ | ____ Appearance of smile | ☐ | ☐ |
| ____ Sensitive teeth | ☐ | ☐ | ____ Unable to chew effectively | ☐ | ☐ |
| ____ Missing teeth | ☐ | ☐ | ____ Bad breath/taste | ☐ | ☐ |
| ____ Loose teeth | ☐ | ☐ | ____ Gum problems | ☐ | ☐ |
| ____ Tooth pain | ☐ | ☐ | ____ Moving teeth | ☐ | ☐ |
| ____ Dry mouth | ☐ | ☐ | ____ Denture/plate problems | ☐ | ☐ |
| ____ Headache | ☐ | ☐ | ____ Limited ability to open mouth | ☐ | ☐ |
| ____ Ear pain | ☐ | ☐ | ____ Jaw joint locking | ☐ | ☐ |
| ____ Jaw pain | ☐ | ☐ | ____ Jaw joint noises | ☐ | ☐ |
| ____ Pain when chewing | ☐ | ☐ | ____ Ear congestion | ☐ | ☐ |
| ____ Facial pain | ☐ | ☐ | ____ Sinus congestion | ☐ | ☐ |
| ____ Throat pain | ☐ | ☐ | ____ Tinnitus (ringing in ears) | ☐ | ☐ |
| ____ Neck pain | ☐ | ☐ | ____ Muscle twitching | ☐ | ☐ |
| ____ Shoulder pain | ☐ | ☐ | ____ Fatigue | ☐ | ☐ |
| ____ Back pain | ☐ | ☐ | ____ Vision problems | ☐ | ☐ |
| ____ Frequent snoring | ☐ | ☐ | ____ Feeling unrefreshed in morning | ☐ | ☐ |
| ____ Teeth grinding | ☐ | ☐ | ____ Stopping breathing during sleep | ☐ | ☐ |

Other, please state:

Have you experienced headaches? YES ☐ NO ☐

If yes, please describe the head pain below:

| LOCATION | | | | Recent | Chronic (6mth+) | Severity | | | Duration | | | Frequency | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| L=Left R=Right B=Both sides | | | | | | Mild | Mod | Severe | Min. | Hrs. | Days | Occasional | Frequent | Constant |
| L | R | B | Frontal (Forehead) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| L | R | B | Generalised | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| L | R | B | Parietal (Top of head) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| L | R | B | Occipital (Back of head) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| L | R | B | Temporal (Temple area) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

## Patient History

How many tea &/or coffees do you drink a day?

How much alcohol do you drink? Please specify type & quantity:

How many soft drinks, cordial or juice do you drink per day?

How much water do you drink in a day?

Do you chew chewing gum? If so, please specify length of chewing & how often:

Do you snack throughout the day? If so, please specify type of snack and when during the day:

Describe: your occupation, work habits, activities, physical exercise, hobbies etc.

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## Sleep History

| | | |
|---|---|---|
| Do you snore? | Yes ☐ | No ☐ |
| Can you get to sleep easily? | Yes ☐ | No ☐ |
| Do you have difficulties breathing through your nose when lying down? | Yes ☐ | No ☐ |
| Do you stay asleep throughout the night? | Yes ☐ | No ☐ |
| Do you wake up rested? | Yes ☐ | No ☐ |
| What is your preferred sleep position? (please circle) | Back | Side Stomach |

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired. This refers to your usual way of life in recent times. Even if you have not done any of these things recently, try to work out how they would have affected you.
Use the following scale to choose the most appropriate colour for each situation:

no chance of dozing | slight chance of dozing | moderate chance of dozing | high chance of dozing

| | CHANCE OF DOZING |
|---|---|
| Sitting and reading | |
| Watching TV | |
| Sitting inactive in a public place (e.g. a theatre or meeting) | |
| As a passenger in a car for an hour without a break | |
| Lying down to rest in the afternoon when circumstances permit | |
| Sitting and talking to someone | |
| Sitting quietly after a lunch without alcohol | |
| In a car, while stopped for a few minutes in traffic | |

Is there anything else about having dental treatment that you would like us to know?

In the unlikely event of a needlestick injury occurring to one of our staff, would you be willing to undergo a blood test? YES / NO

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be required, you have my permission to ask the respective health care provider, who may release such information to you. I will notify the dentist of any change in my health or medication.

Patient/Guardian Signature:

Date: