Royal Dental Practice

Roya Shoffet-Yaghoubian, D.M.D., D.D.S.
Family & Cosmetic
Dentistry

PATIENT'S NAME ___________________________ SS# _________________ OCCUPATION __________________

REASON FOR VISITING ____

PLEASE ANSWER ALL QUESTIONS BY MARKING YES OR NO. YOUR RESPONSE TO THIS QUESTIONNAIRE WILL BE HELD STRICTLY CONFIDENTIAL AND WILL ONLY BE USED TO ASSIST IN THE ASSESSMENT OF YOUR MEDICAL CONDITION. IF YOU HAVE ANY HESITATIONS PLEASE DISCUSS YOUR CONCERN WITH ONE OF THE FACULTY MEMBERS.

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

Cardiovascular Disorders:

YES NO
- □ □ High blood pressure
- □ □ Congenital heart disease
- □ □ Rheumatic fever
- □ □ Heart murmur
- □ □ Heart pacemaker
- □ □ Vascular graft
- □ □ Heart or bypass surgery
- □ □ Artificial heart valve
- □ □ Heart attack
- □ □ Congestive heart failure
- □ □ Awaken with breathing difficulty
- □ □ Angina pectoris / chest pain
- □ □ Swollen ankles
- □ □ Irregular or rapid heart beats
- □ □ Stroke

Respiratory Disorders:

YES NO
- □ □ Emphysema or asthma
- □ □ Hay fever
- □ □ Chronic cough or bronchitis
- □ □ Tuberculosis (TB)
- □ □ Chronic sinusitis
- □ □ Breathing problems

Musculo-Skeletal / CNS / Developmental Disorders:

YES NO
- □ □ Frequent headaches
- □ □ Fainting spells or loss of consciousness
- □ □ Seizures or epilepsy
- □ □ Visual impairment
- □ □ Hearing impairment
- □ □ Artificial joint
- □ □ Arthritis or bone disease
- □ □ Muscle disease
- □ □ Spinal cord injury or paralysis

YES NO
- □ □ Cerebral palsy
- □ □ Mental retardation / autism
- □ □ Alzheimer's disease or other dementia

Gastrointestinal/Genitourinary Disorders:
- □ □ Colitis or ulcers
- □ □ Hepatitis or other liver disease
- □ □ Jaundice
- □ □ Renal dialysis / transplant
- □ □ Kidney disease
- □ □ Syphilis, gonorrhea or other sexually transmitted diseases
- □ □ Genital herpes
- □ □ Frequent canker sores
- □ □ Frequent cold sores
- □ □ Chronic diarrhea
- □ □ Frequent vomiting
- □ □ History of Fen-Phen

Hematologic / Endocrine / Immune Disorders
- □ □ Blood transfusion
- □ □ Denied permission to give blood
- □ □ Anemia / leukemia / lymphoma
- □ □ Hemophilia
- □ □ Sickle cell disease
- □ □ Blood clots or thrombosis
- □ □ Diabetes
- □ □ Thyroid disease
- □ □ Adrenal gland disease
- □ □ AIDS
- □ □ HIV infection
- □ □ Bleeding or bruising tendency
- □ □ Sudden weight loss or gain
- □ □ Frequent thirst

YES NO
- □ □ Frequent hunger
- □ □ Frequent urination
- □ □ Cancer / radiotherapy / chemotherapy
- □ □ Systemic lupus

Psychiatric

YES NO
- □ □ Nervousness
- □ □ Depression
- □ □ Anxiety
- □ □ Past / present psychiatric treatment

Family History (Grandparents, Parents, Sisters, Brothers, Children):

YES NO
- □ □ Diabetes
- □ □ Heart disease
- □ □ Bleeding disorders

Allergies:

YES NO
- □ □ Penicillin / sulfa drugs
- □ □ Novocain / Xylocaine / dental anesthetics
- □ □ Aspirin / codeine
- □ □ Latex products
- □ □ Other _______________

Females :

YES NO
- □ □ Are you pregnant now? ______ # months
- □ □ Are you practicing birth control?
- □ □ Do you anticipate becoming pregnant?
- □ □ Are you breast feeding now?

Dental History:

YES NO
- ☐ ☐ Are you having pain or discomfort related to your mouth?
- ☐ ☐ Do you feel nervous about having dental treatment?
- ☐ ☐ Have you ever had a bad experience in a dental office?

Social History:

YES ____ NO ____ Do you use tobacco?
What kind? ____
How much? ____
How many years? ________________________________

YES ____ NO ____ Do you drink alcoholic beverages?
What kind? ____
How much per day? ______________________________
How many years? ________________________________

YES ____ NO ____ Past or current history of drug addiction.

Do you have any other conditions not already mentioned?
____
____

History of Hospitalization / Surgical Procedures:
____
____
____
____

Current Medications:

Prescribed and over-the-counter medications taken within the last six months.

____
____
____
____
____

To the best of my knowledge, all the preceding answers are true. If I ever have any change in my health, or my medicines change, I will inform my dental health care provider at my next appointment.

____ ____
date *signature of patient, parent or guardian*

Soft Tissue Examination (*Indicate lesions on drawings, describe, and date)*

Head, Neck, T.M.J. ____________________.
Lips / Frenum ____________________.
Mucosa ____________________.
Palate ____________________.
Pharynx ____________________.
Floor of Mouth ____________________.
Tongue ____________________.
Gingiva ____________________.
Lymph Nodes ____________________.
Salivary Glands ____________________.
Thyroid ____________________.

Significant Radiographic Findings ____
____
____
____
____
____.