15321 San Pedro Ave, Ste 103
San Antonio, TX 78232
210.654.7878

6502 Bandera Rd, Ste 102
San Antonio, TX 78238
210.680.0706

SOUTH TEXAS PERIODONTAL ASSOCIATES
... restoring healthy smiles

Dr Brian Beck DDS MS
Dr Adam Christman MSD DDS

HEALTH QUESTIONNAIRE

Name _____ SSN _____ DOB_____

Ht. _____ Wt. _____ Marital Status _____ Name of Spouse _____

Home Address _____ City _____ Zip _____

Phone _____ Email _____ Cell Phone _____

Bus. Address _____ City _____ Zip _____ Bus. Phone _____

Party responsible for payment of this account _____

Your Dentist _____ Your Physician _____ Physician Phone _____

Date of last dental visit _____ for _____ Date of last physical _____

Do you have Dental Insurance? _____ Insurance Company _____

_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ *If you have Insurance, please bring a claim form with you* _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

HEALTH EVALUATION: What is your impression of your present health? _____

Do you have or have you had:

HEART CONDITION	Y	N	ASTHMA	Y	N	RADIATION THERAPY	Y	N
HEART SURGERY	Y	N	EMPHYSEMA	Y	N	CANCER	Y	N
RHEUMATIC FEVER	Y	N	TUBERCULOSIS	Y	N	ANEMIA	Y	N
HEART MURMUR	Y	N	JAUNDICE	Y	N	KIDNEY DISEASE	Y	N
ANGINA/CHEST PAIN	Y	N	HEPATITIS	Y	N	THYROID DISEASE	Y	N
HIGH BLOOD PRESSURE	Y	N	LIVER DISEASE	Y	N	SHORTNESS OF BREATH	Y	N
LOW BLOOD PRESSURE	Y	N	DIABETES	Y	N	ARTHRITIS	Y	N
LUNG DISEASE	Y	N	GLAUCOMA	Y	N	SEVERE HEADACHES	Y	N
SEIZURES/EPILEPSY	Y	N	STROKE	Y	N	HIV/AIDS	Y	N
SEXUALLY TRANSMITTED DISEASE				Y	N	HIVES/SKIN RASH	Y	N

Are you pregnant?	Y	N
Are you taking birth control pills?	Y	N
Have you been hospitalized or under the care of a physician in the past year?	Y	N
Are you presently taking any medications or drugs? (if yes please list on the back)	Y	N
Do you take aspirin on a regular basis?	Y	N
Have you taken cortisone or steroids within the past 2 years?	Y	N
Have you had a major illness or injury in the past 5 years?	Y	N
Have you ever had a reaction to local anesthetic?	Y	N
Have you ever had instances of prolonged or unusual bleeding?	Y	N
Have you ever had stomach ulcers?	Y	N
Are you taking any antidepressants?	Y	N

Are you allergic to any of the following?

□ Aspirin	□ Penicillin	□ Codeine	□ Local Anesthetics
□ Metal	□ Acrylic	□ Latex	□ Sulfa Drugs
□ Tetracycline	□ Erythromycin	□ Barbiturates	□ Cephalexin
□ Ibuprofen	□ Tylenol	□ Valium	□ Ativan

□ Other _____

How would you describe your dental health? (Poor) 1 2 3 4 5 (Excellent)

Where would you like your dental health to be? (Poor) 1 2 3 4 5 (Excellent)

Have you had instruction in oral hygiene methods?..... Y N

Do you feel your present oral hygiene routine is effective? ..... Y N

Are your teeth sensitive to hot or cold? ..... Y N

Have you ever had a dental abscess? ..... Y N

Have you had orthodontic treatment (braces)? ..... Y N

Do you feel that you chew satisfactorily? ..... Y N

Have you noticed your teeth shift? ..... Y N

Do you awaken with sore jaws in the morning? ..... Y N

Do you clench or grind your teeth? ..... Y N

Do you notice clicking, popping, or soreness in the joint in front of your ears? ..... Y N

Do you have frequent headaches? ..... Y N

Do you smoke or use tobacco products? ..... Y N

What was the date of your last full mouth dental X-rays? ..... Y N

Have you had gum treatment or gum surgery before? Yes No When?_____

Pharmacy information: Name _____ Address _____ Phone _____

What concerns you most about your teeth and mouth? _____

_____

Do you have any disease, condition, or problem not listed in the previous Health Questionnaire? _____

_____

Please list all medications you are currently taking _____

_____

_____

Blood Pressure _____

Patient Signature (or legal guardian):_____

Date _____

Thank you for your time in filling out this health questionnaire. It will help us tremendously to clearly evaluate your dental concerns and plan the safest method of treatment.

Signature of Dentist _____