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

Dr Adam Christman MS DDS MSD

Name ____________________________________ Marital Status_________ Name of Spouse ______________________

SS# ___________________________ DOB_____________________ Ht. ________ Wt. ________

Email____

Home Address ____City __________________ Zip ____________

Home Phone _________________ Cell Phone ______________________________________

Emergency Contact __________________________________ Relationship _____________Phone ____________________

Your Dentist ________________________ Your Physician _____________________________

Date of last dental visit ______________ for ____

HEALTH EVALUATION:

Do you have or have you had any of the following:

HEART CONDITION	Y	N	CANCER	Y	N	KIDNEY DISEASE	Y	N
STROKE	Y	N	RADIATION THERAPY	Y	N	THYROID DISEASE	Y	N
RHEUMATIC FEVER	Y	N	ASTHMA	Y	N	SEVERE HEADACHES	Y	N
ANGINA/CHEST PAIN	Y	N	SHORTNESS OF BREATH	Y	N	GLAUCOMA	Y	N
HEART SURGERY	Y	N	EMPHYSEMA	Y	N	HIV/AIDS	Y	N
HEART STENT	Y	N	LUNG DISEASE	Y	N	STD/STI	Y	N
HEART BYPASS	Y	N	SEIZURE/EPILEPSY	Y	N	COLD SORES	Y	N
PACEMAKER/DEFIBRILLATOR	Y	N	JAUNDICE	Y	N	ANEMIA	Y	N
HIGH BLOOD PRESSURE	Y	N	HEPATITIS A,B,C	Y	N	ARTHRITIS	Y	N
LOW BLOOD PRESSURE	Y	N	LIVER DISEASE	Y	N	DIABETES- A1C:____	Y	N
JOINT REPLACEMENTS	Y	N	TUBERCULOSIS	Y	N			

Are you pregnant or is there a chance you could be pregnant?.. Y N
Are you taking any form of birth control?... 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 ever had instances of prolonged or unusual bleeding? .... Y N
Do you use tobacco products?.. Y N
If yes, how much/how often? ____
Have you ever had stomach ulcers? .... Y N
Are you taking any antidepressants?... Y N

- Certain anti-anxiety and/or antidepressants can change the efficacy of sedatives

Are you ***allergic*** to any of the following? ☐ Aspirin ☐ Penicillin/Amoxicillin ☐ Codeine ☐ Metal ☐ Acrylic ☐ Latex ☐ Sulfa Drugs

Last update: October 2018

☐ Tetracycline ☐ Erythromycin ☐ Barbiturates ☐

Cephalexin

☐ Ibuprofen ☐ Tylenol ☐ Valium ☐ Ativan

Have you ever had a reaction to local anesthetics? Y N

Other Allergies____

Please list all medications you are currently taking, including over the counter medications or supplements:

____

____

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

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

Y N

Do you currently have a dental abscess? Y N Are you currently taking antibiotics for abscess? Y N

Have you ever had a dental abscess?

.... Y N

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

Y N

Do you have any problems chewing/eating?...

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

Have you had gum treatment or gum surgery before? ....

Y N

Are you interested in Oral or IV sedation for any future dental procedure?... Y N

What concerns you most about your teeth and mouth?

____

____

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

____

____

Last update: October 2018

Please list any surgeries or hospitalizations

____

____

Does your physician require you to premedicate with antibiotics prior to dental procedures?................. Y N

Preferred Pharmacy______________________ Address_____________________________Phone_________________

Patient Signature (or legal guardian):____

Date ____________________

Reviewed and Updated _______________________

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.

Last update: October 2018