Welcome

GERALD R. RYAN, D.D.S.

CONFIDENTIAL PATIENT QUESTIONNAIRE

Today's Date: ________________

Patient's Name ________________________________ Name Patient Goes By: ____________

Address: ______________________________ City: ____________________ Zip: ____________

Home Phone: ( ) __________ Work Phone: ( ) __________ Cell Phone:( ) __________

Birth Date: M______ D _____ Yr _____ Age: _____ Soc. Secur. #: ________________

Spouse's Name: ________________________________ Soc. Secur. #: ________________

Patient Employed By: ____________________________ Occupation: ________________

Business Address: ____

Spouse Employed By: ____________________________ Occupation: ________________

Spouse's Business Address: ____

Do you have insurance that may cover any part of our professional services? ❑ YES ❑ NO

WHOM MAY WE THANK FOR REFERRING YOU? ________________________________

MEDICAL HISTORY

Physician's Name: ______________________________

Address: ______________________________

City and Phone: ______________________________

	YES	NO
1. Are you being treated for any condition by a physician now?	❑	❑
2. Have you ever been seriously ill or had a major operation?	❑	❑
3. Have you ever had a blood transfusion?	❑	❑
4. List medications you are currently taking	❑	❑

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	YES	NO
5. Have you ever been told you are antibody positive for the AIDS virus?	❑	❑
6. Do you have any reason to suspect that you may have been exposed to a communicable disease such as hepatitis or the AIDS virus?	❑	❑
7. Have you ever experienced a bad reaction to any of the following drugs?		
Aspirin	❑	❑
Penicillin	❑	❑
Iodine	❑	❑
Erythromycin	❑	❑
Codeine	❑	❑
Tetracycline	❑	❑
Dental Anesthetic	❑	❑
Other Medicines	❑	❑

Please List ______________________________

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(Continued on Back)

MEDICAL HISTORY (Continued)

	YES	NO
8. Have you ever had any of the following?		
Rheumatic Fever	❑	❑
Arthritis	❑	❑
Hepatitis (yellow skin and eyes)	❑	❑
Diabetes (sugar disease)	❑	❑
High Blood Pressure	❑	❑
Tuberculosis	❑	❑
Venereal Disease	❑	❑
Asthma	❑	❑
Heart Attack	❑	❑
AIDS	❑	❑
Stroke	❑	❑
Epilepsy	❑	❑
Heart Murmur	❑	❑
Mitro Valve	❑	❑
9. Do you have any of the following?		
Severe Headaches	❑	❑
Nosebleeds	❑	❑
Chest Pain on Exertion	❑	❑
Shortness of Breath on Mild Exertion	❑	❑
Frequent Indigestion	❑	❑
Tendency to Faint	❑	❑
Bleeding For A Long Time When You Cut Yourself	❑	❑
Any Blood Disorder	❑	❑
10. Women: Are you presently pregnant?	❑	❑

DENTAL HISTORY

	YES	NO
11. Have you ever had any injury to your face or jaws?	❑	❑
12. Have you ever had surgery or x-ray treatment for a tumor, growth or other condition in your mouth or on your lips?	❑	❑
13 Are you dissatisfied with the appearance of your teeth?	❑	❑
14. Are you worried about receiving dental treatment?	❑	❑
15 Do you have difficulty in chewing your food?	❑	❑

DENTAL HISTORY (Continued)

	YES	NO
16. Do you frequently snack between meals .... on Sweets?_____ Starches?_____ Chewing Gum?_____ Soft Drinks?______	❑	❑
17. Do you have any sensitive teeth?	❑	❑
18. Have you had a toothache recently?	❑	❑
19. Do you have bleeding gums?	❑	❑
20. Do you have frequent canker sores or cold sores?	❑	❑
21. Are you aware of clenching or grinding your teeth?	❑	❑
22. Have you been under more than average nervous tension lately?	❑	❑
23 When did you last have your teeth cleaned? ____________ How often have you had your teeth cleaned in the last 10 years? ____________		
24. Have you ever had periodontal (gum) treatment? When?____________	❑	❑
25. Have you ever had orthodontic treatment (teeth straightened)?	❑	❑
26. Indicate approximate date of last tooth extraction:____________ Any associated bleeding or healing problems?	❑	❑
27. Have any of your teeth recently separated, creating spaces between them?	❑	❑
28. Do you daily use dental floss, rubber tip, or stimudents? Which? ____________	❑	❑
29. Do you smoke? What and how much? ____________	❑	❑
30. Do you use chewing tobacco?	❑	❑
31. Would you be greatly disturbed if you had to lose all your teeth?	❑	❑
32. Did either of your parents lose all their teeth?	❑	❑
33. Are you satisfied with your past dentistry?	❑	❑

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Patient's Signature Date