

FLORIDA ATLANTIC UNIVERSITY, STUDENT DENTAL SERVICES

Patient's Name:	SS#:	Telephone #: ()
Patient's Dentist:	Address:	Telephone #: ()
Patient's Physician:	Address:	Telephone #: ()
Date of Last Dental Visit:	Last Cleaning:	Last X-rays:
Age:	Reason for Visit:	

Dental Health Questionnaire

- | | |
|--|---|
| <p align="center">Yes No</p> <ol style="list-style-type: none"> 1. Do you have a swelling in the roof of your mouth? 2. Have you noticed purplish color on your gums? 3. Do your gums bleed sometimes? 4. Are your teeth painful? 5. Can you chew well on both sides of your mouth? 6. Have you ever had any excessive bleeding requiring special treatment? 7. Currently taking medication?
Please list | <p align="center">Yes No</p> <ol style="list-style-type: none"> 8. Are you pregnant? 9. Have you had any cold sores or cankers on your lips, tongue, gums or body? 10. Do you have artificial heart valves, mitral valve prolapse, pacemaker, heart murmur, artificial joints, steel rods or pins? 11. Have you ever taken antibiotics prior to dental cleaning or treatment? 12. Allergies to latex or medicine?
Please list |
|--|---|

Signature of student _____

Date _____

Do not write below this line

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Oral Examinations

Habit History

	Normal	Abnormal	Comments
1. Pharynx	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Palate			_____
a. Soft	<input type="checkbox"/>	<input type="checkbox"/>	_____
b. Hard	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Cheeks	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Lips	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Tongue	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Floor of Mouth	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Swellings	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Others: _____			_____

	Yes	No
1. Foreign Objects	<input type="checkbox"/>	<input type="checkbox"/>
2. Clenching	<input type="checkbox"/>	<input type="checkbox"/>
3. Grinding	<input type="checkbox"/>	<input type="checkbox"/>
4. Lip, Cheek, Tongue-Biting	<input type="checkbox"/>	<input type="checkbox"/>
5. Awakening with teeth together	<input type="checkbox"/>	<input type="checkbox"/>
6. Numb or Wooden Feeling	<input type="checkbox"/>	<input type="checkbox"/>
7. Positive Occ. Sense	<input type="checkbox"/>	<input type="checkbox"/>
8. Tongue Thrusting	<input type="checkbox"/>	<input type="checkbox"/>
9. Reverse Swallowing	<input type="checkbox"/>	<input type="checkbox"/>
10. Smoker	<input type="checkbox"/>	<input type="checkbox"/>

