

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

	Yes	No		Yes	No
1. Do you have a swelling in the roof of your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	8. Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you noticed purplish color on your gums?	<input type="checkbox"/>	<input type="checkbox"/>	9. Have you had any cold sores or cankers on your lips, tongue, gums or body?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do your gums bleed sometimes?	<input type="checkbox"/>	<input type="checkbox"/>	10. Do you have artificial heart valves, mitral valve prolapse, pacemaker, heart murmur, artificial joints, steel rods or pins?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are your teeth painful?	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you ever taken antibiotics prior to dental cleaning or treatment?	<input type="checkbox"/>	<input type="checkbox"/>
5. Can you chew well on both sides of your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	12. Allergies to latex or medicine?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had any excessive bleeding requiring special treatment?	<input type="checkbox"/>	<input type="checkbox"/>	Please list _____		
7. Currently taking medication? Please list _____	<input type="checkbox"/>	<input type="checkbox"/>	_____		

Signature of student _____

Date _____

Do not write below this line

	Comments: _____ _____ _____
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Oral Examinations

	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: _____			_____

Habit History

	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"/>

