FLORIDA ATLANTIC UNIVERSITY STUDENT HEALTH SERVICES DENTAL CLINIC

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

Dental Health Questionnaire

	Yes	No
1. Do you have any pain in your mouth today? If yes, where? (please circle) gum / tooth / other	☐	☐
2. Do you have any bleeding in your mouth today? If yes, where? (please circle) gum / tooth / other	☐	☐
3. Do you have any swelling in your mouth today? If yes, where? (please circle) gum / tooth / other	☐	☐
4. Do you have any of the following (please check)? ☐ Dry mouth or difficulty chewing ☐ Temporal mandibular joint (TMJ) pain, discomfort, other ☐ Lesions in or around your mouth ☐ Discolored or stained teeth ☐ Bad breath ☐ Teeth sensitivity to cold/hot/sweet ☐ Other_____	☐	☐
5. Have you been diagnosed with asthma?	☐	☐
6. Have you been diagnosed with hepatitis, AIDS, TB or other immune system problems?	☐	☐
7. Have you been diagnosed with diabetes? If yes, which type? (please circle) Type 1 / Type 2	☐	☐
8. Do you have any bleeding disorder or take blood thinners?	☐	☐
9. Have you ever had seizures?	☐	☐
10. Have you had joint replacement surgery?	☐	☐

	Yes	No
11. Do you have an artificial heart valve, heart transplant, or congenital heart problems?	☐	☐
12. Have you ever had infectious endocarditis?	☐	☐
13. Are you allergic to any of the following (please check)? ☐ Latex ☐ Local anesthesia ☐ Fruit flavoring ☐ Gluten ☐ Nuts ☐ Milk protein ☐ Clove oil ☐ Any other medication or substance If yes, please list_____	☐	☐
14. Are you currently taking any medications, including contraceptives, supplements, and over the counter medications? If so, please list_____	☐	☐
15. Are you pregnant?	☐	☐

Dental habits (please circle answer)

1. Do you grind or clench your teeth? Yes No
2. Do you chew on ice or other foreign objects? Yes No
3. Do you smoke? Yes No
4. How many times a day do you brush your teeth? 1 2 3
5. Do you use dental floss? Yes No
6. Other habits? _____

Signature of student Date

Provider's Signature Date