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:	Reason for Visit:	

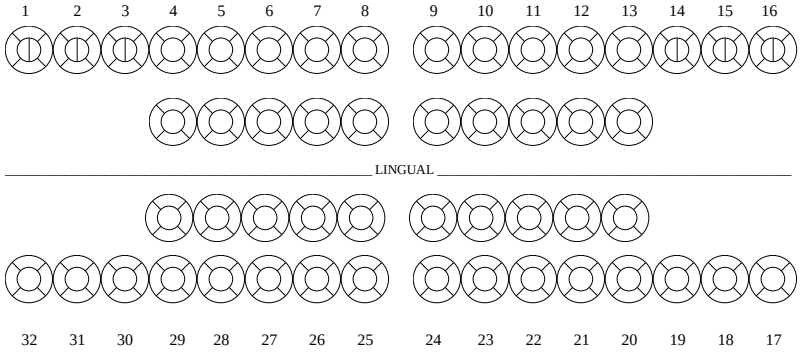
Dental Health Questionnaire

	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?	☐	☐

Signature of student Date

Do not write below this line



Comments: _____

Signature of Student Health Services Staff Date