Scott O. Schulz, DDS, MS, PC

PATIENT INFORMATION & HEALTH HISTORY

TELL US ABOUT YOURSELF

Patient Name:______________________Age:________Birthdate:____________Sex:____________

Home Address:______________________Home Phone:______________________

______________________Fax Number:______________________

You prefer to be called:______________________E-Mail Address:______________________

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Other______________

Other family members seen in our office:______________________

Person Responsible for Financial Matters

Name(s):______________________ ______________________

Address: ______________________ ______________________

______________________ ______________________

Home Phone:______________________ ______________________

Business Phone:______________________ ______________________

Place of Employment:______________________ ______________________

Social Security Number:______________________ ______________________

	Family Dentist	**Family Physician**	**Referred By**
Name:	______________	______________	______________
Address:	______________	______________	______________
Last Appointment:	______________	______________	______________

Frequency of dental visits/cleaning:______________ ______________Brushings a day

Medical History: Have you ever had:

☐Allergy – Latex_Metal___
☐Anemia
☐Arthritis
☐Artificial Joints/Valves
☐Asthma/Difficulty Breathing
☐Birth Defects/Congenital Defects
☐Blood Transfusion
☐Cancer
☐Cold Sores
☐Diabetes
☐Emphysema
☐Endocrine Problems
☐Epilepsy/Seizures
☐Glaucoma
☐Headache/Migraines
☐Heart Attack/Stroke
☐Heart Surgery/Pacemaker
☐Heart Condition/Murmur
☐Head or Face Injury
☐Hemophilia
☐Hepatitis
☐Herpes
☐HIV Positive
☐High/Low Blood Pressure
☐Kidney/Liver Disease
☐Mirtral Valve Prolapse
☐Oral Ulcer
☐Previous Surgery
☐Psychiatric Problems
☐Rheumatic Fever
☐Sinus Problems
☐Thyroid Problems
☐Tuberculosis
☐Other (Describe Below)

Comments:______________________

Has the patient been under the care of a physician during the past two years, other than for routine examination? No Yes
Condition:______________________

Do you require antibiotic premedication for dental procedures? No Yes

Present drugs or medications:______________________

Do you smoke cigarettes? No Yes How frequent? ______________

Scott O. Schulz, DDS, MS, PC

Are you pregnant? No Yes

Respiratory History – Do you:

1. Have allergies to: Seasonal grasses:________ Food:________
   Drugs:________ Others:________

	Seldom	Sometimes	Usually
2. Breathe through mouth?	Seldom	Sometimes	Usually
3. Snore when sleeping?		No	Yes
4. Have frequent colds?		No	Yes
5. Have frequent "stuffy nose"?		No	Yes
6. Have frequent sore throat or tonsillitis?		No	Yes
7. Have chewing or swallowing difficulties?		No	Yes

Have you received medical treatment from an allergist or ear, nose, and throat specialist? No Yes
If Yes: When________By Whom:________
Nasal Surgery:________Tonsils removed:________Adenoids removed:________

Dental and Temporomandibular Joint History

Have you had any unusual dental experiences? No Yes
Specify:________

Have you ever been treated for TMJ ("Jaw Joint") problems? No Yes

Do you have:

1. Difficulty in mouth opening?	No	Yes
2. Pain or clicking of jaw joint?	No	Yes
3. Pain on chewing, yawning, or wide opening?	No	Yes
4. Pain in or about the ears or cheeks?	No	Yes
5. A bite that feels "uncomfortable" or "unusual"?	No	Yes
6. A jaw that "locks", "gets stuck", or "goes out"?	No	Yes
7. Noises in or from the jaw joints?	No	Yes

The following habits are of interest. List information as it pertains to you:

1. Thumb/finger/lip sucking until________(Age)	No	Yes
2. Grinding or clenching of teeth	No	Yes
3. Tongue thrusting or other functional problem	No	Yes

Have you had a previous orthodontic consultation? No Yes Treatment? No Yes

Date:________Doctor:________City, State:________

Why did you seek consultation?________

What is the primary problem?________

____

What do you expect from orthodontic treatment?________

____

Additional comment you wish to make:________

____

Signature:________ **Date:**________