

CENTER FOR DENTISTRY Faculty Dental Practices

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School of Dentistry

Orofacial Pain Management

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E	P	ermission is	granted	to student	s, staff, ar	nd faculty	to perfo	rm pro	cedures, i	ncluding the	e giving of anes	thetics or taking of ph	iotograp	ohs wh	ich may b	e nece	essary
SE	to	or my denta	l treatmei	nt or for te	aching pu	irposes. I	have the	right to	o refuse ai	ny procedure	e. I will be resp	onsible if I terminate	treatme	nt agai	nst denta	l advis	ie.
CONSENT																	
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3. D	o yo	ou drink ale	coholic b	everages?	If Yes, he	ow much	?			••••••	••••••	••••••	•••••		••••••		
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8. D	o yo	ou feel that	you are	currently	more tire	ed than u	sual?				*****	•••••	•••••				
9. D	o yo	ou have ma	ny body	aches and	l pains?		•••••	• • • • • • • • • • • • • • • • • • • •				······	•••••	•••••			
10.	Do y	ou have ni	ght swea	ts or recu	rring fev	er?	•••••	•••••		•••••	•••••	••••••	•••••	•••••			
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DENTAL CENTER

HEALTH QUESTIONNAIRE

Do you have or have you ever had:			Do you have or have you ever had:		
GASTROINTESTINAL/GENITO-URINARY	YES	NO	HEMA/ENDO/IMMUNE	YES	NO
72. Persistent diarrhea/odd colored stools			91. Bruise easily/bleed excessively after a cut		
73. Colitis or ulcers			92. A blood transfusion		
74. Unexplained vomiting/frequent nausea			93. Anemia or denied permission to give blood		
75. Alcoholic liver disease			94. Diabetes or been frequently thirsty		
76. Hepatitis or other liver disease			95. Thyroid or adrenal gland disease		
77. Jaundice (yellow skin or eyes)			96. Leukemia (cancer of the blood)		
78. Awaken more than twice a night to urinate			97. AIDS or ARC (AIDS Related Complex)		
79. Kidney disease/renal dialysis			98. Positive blood test for HIV antibodies		
80. A kidney transplant			99. Skin blotches or rash		
81. Any urinary infection			100. Rheumatoid arthritis		
82. Syphilis			101. Chronic itching		
83. Gonorrhea					
84. Any other sexually transmitted disease				*	
			WOMEN ONLY	YES	ИО
Have you been allergic to or had a bad reaction			102. Do you menstruate regularly?		
ALLERGIES	YES	NO	103. Do you flow heavily?		
85. Penicillin			104. Are you now pregnant?		
86. Sulfa drugs			105. If so, please give due date		
87. Dental anesthetics	SECOND CONTRACTOR OF THE PROPERTY OF THE PROPE		106. Are you in or have you passed through		
88. Narcotics			menopause (change of life)?		
89. Dairy Products			107. Are you taking hormones?		
90. Other (Specify)			108. Are you taking birth control pills?		
Has anyone in your family (grandparent, pare FAMILY HISTORY	YES	ild) eve NO		YES	NO
109. Bleeding disorder			113. Cancer		
110. Heart disease			114. Tuberculosis		
111. Mental/emotional disorders			115. Diabetes		
112. Any genetic diseases/illnesses (please specify) BEHAVIORAL				YES	NO
117. Are there some aspects of the appearance of your 118. Do you often feel depressed or moody?	r teeth and jaw ounseling? e you were frigl	that need	l to be changed?		
List all prescription and non-prescription drugs (In	cluding aspiri	n) taken	within the past 6 months:		
Name Dosage	Name		Dosage Name	Dosage	
14			7		
2 5	i		8		<u> </u>
3	5		9		
Please list all hospitalizations and emergency room	visits (include	dates ai	nd reasons):		
1.			4		
2			5	<u> </u>	
3			6	- Company of the Comp	
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CENTER FOR DENTISTRY Faculty Dental Practices

DATE:_		

REGISTRATION

Who referred you to the Pain I	Management?	
Name		
City	State	Zip
Phone Number () _		
Please provide us with the nam	nes and complete addresses of your doctors	
DENTIST		and and
Name		
Address		
		Zip
PHYSICIAN		
Name		
		Zip
If you have other health care p	oractitioners who are actively involved in	your treatment, please provide us with their
SPECIALTY		
Name		
Address		
City	State	Zip
Phone Number ()		
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