FUGAZZOTTO, ROST & BRODSKY DDS DMD, MSD DMD, MSD
Periodontics & Implants

& Reflections Medical Spa

Health Questionnaire

Date: _____

Name: _____ DOB: ____/_____/____ SS#: _____-____-_____

Address: _____ City/State/Zip: _____

Email: _____

Phone (home): _____ (cell): _____ (work): _____

Referred by: _____Family Dentist:_____

Primary Care Physician: _____Last Visit:_____

Dental Insurance: _____

Medical History

Do you have anything implanted in your body? _____ If yes, where: _____

Have you ever been tested for HIV? ☐ If yes, result: ☐Positive ☐Negative

Please list any medications you are taking:

_____

Do you take medications for osteoporosis? ☐yes ☐no Do you take blood thinners: ☐ yes ☐ no

Have you ever taken Accutane? ☐yes ☐no

Do you have any allergies? _____

Please circle any of the following you have or have ever had in the past:

Heart Disease	Ulcers	Cancer
Heart Murmur	Glaucoma	Eye Disease
High Blood Pressure	Stroke	ALS
Blood Disorders	Sinus Trouble	Vision Problems
Liver Problems	Arthritis	Muscle weakness
Hepatitis	Nervous Disorder	Myasthenia Gravis
Diabetes	Asthma	Parkinson's Disease
Epilepsy	Lung Disorder	Numbness
Severe Allergies	Autoimmune Disease	Multiple Sclerosis
History of Cold Sores	Allergy to beef/dairy	Gold Therapy
Keloid Formation	Lupus	

Continued →

Do you suffer from frequent or severe headaches? ☐yes ☐no

Have you ever had radiation and/or chemo therapy? ☐yes ☐no

Do you smoke and/or vape? ☐yes ☐no

Do you drink alcohol? ☐yes ☐no If yes, how often? _____

Do you feel rested when you wake up? ☐yes ☐no

Are you tired during the day? ☐yes ☐no

Do you fall asleep watching TV, reading, or as a passenger in a car? ☐yes ☐no

Dental History

Please describe your present dental problem: _____.

Are you having any discomfort or pain? ☐yes ☐no If yes, where? _____

Do your gums bleed when you brush or floss? ☐yes ☐no

Do you have a "bad taste" in your mouth? ☐yes ☐no

Are your teeth sensitive to hot, cold, or sweets? ☐yes ☐no

Do you have enough teeth to chew with? ☐yes ☐no

Are you aware of any loose teeth? ☐yes ☐no

Do you have a removable partial plate or denture? ☐yes ☐no

If yes, would you like more "permanent" teeth? ☐yes ☐no

Are you aware of the advantages of dental implants? ☐yes ☐no

Does your jaw ache when you awake in the morning? ☐yes ☐no

Has your bite "changed" over the last year? ☐yes ☐no

Are you able to open as widely as in the past? ☐yes ☐no

Are you satisfied with the appearance of your teeth? ☐yes ☐no If no, why? _____

Have you had orthodontic therapy (braces)? ☐yes ☐no How long ago? _____

Have you had prior periodontal therapy? ☐yes ☐no How long ago? _____

Are you pregnant? ☐yes ☐no If yes, how many months? _____

Are you taking birth control pills? ☐yes ☐no

Are you taking hormones? ☐yes ☐no

If you have a prosthesis, please call BEFORE your appointment, as you may need antibiotic premedication.

Thank you!

Signature: _____ Date: _____