

DR. SHERRY STEINMETZ



Guest Medical History

Guest Name:

Today's Date:

Empty input boxes for Guest Name and Today's Date

Physician's Name:

Physician's Phone:

Empty input boxes for Physician's Name and Physician's Phone

Pharmacy:

Pharmacy Phone:

Empty input boxes for Pharmacy and Pharmacy Phone

If female please answer the following:

Please answer the following:

Form section for female-specific questions including birth control, pregnancy, nursing, height, weight, and smoking.

Large grid of medical conditions with Y/N checkboxes, including Abnormal Bleeding, Allergies, Angina Pectoris, Artificial Heart Valve, Artificial Joints, Asthma, Cancer- Chemotherapy, Congenital Heart Defect, Congestive Heart Failure, Diabetes, Difficulty Breathing, Fainting Spells, Frequent Headaches, Grapefruit Juice (Drink?), Heart Attack, Hepatitis A, Hepatitis B, Hepatitis C, High Blood Pressure, HIV + AIDS, Liver Disease, Mitral Valve Prolapse, Pace Maker, Pain in Jaw Joints, Prior Endocarditis, Radiation Therapy, Recreation Drugs, Seizures, St. John's Wart, Stroke, Thyroid Problems, and Tuberculosis.

Form section for Allergies with checkboxes for Aspirin, Codeine, Dental Anesthetics, Erythromycin, Jewelry, Latex, Metals, Penicillin, Tetracycline, and an 'Other:' field.

Have you ever been diagnosed with Sleep Apnea?
Have you ever had a sleep study?
Have you been told you should wear a CPAP?

Do you have morning headaches?
Have you been told that you gasp for air or suddenly stop breathing while sleeping?
Do you snore? ?

Medications

Empty input box for listing Medications

Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below...

Empty input box for describing any additional medical information



**Guest Dental History**

*Please take a few moments to answer these questions so that we may cater our services to better meet your needs:*

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

When was the date of your last dental visit? \_\_\_\_\_

Why did you decide to change dental offices? \_\_\_\_\_

Do you feel anxious about seeing a dentist? Y N

Do you have any active dental problems now? Y N

If so, please explain: \_\_\_\_\_

Have you ever been told that you have gum disease? Y N

If so, what treatment, if any, did you have? \_\_\_\_\_

Have you ever been told that you have "TMJ" problems? Y N

If so, please explain: \_\_\_\_\_

Do you clench or grind your teeth? Y N

If so, have you ever had a splint or night guard made for you? Y N

Are your teeth sensitive to temperature changes? Y N

Have you noticed any mouth odors or bad taste in your mouth? Y N

If you could change one thing about your smile, what would it be?

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**The STOP Questionnaire**

**S:** Do you *snore*? Y N

**T:** Do you often feel *tired*, fatigued or sleepy during daytime? Y N

**O:** Has anyone *observed* you stop breathing during sleep? Y N

**P:** Do you have or are you being treated for high blood *pressure*? Y N

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Is there anything else that you would like for us to know about you before your first visit?