**PAUL D. WALTERS, D.M.D.**
502 East Rutherford Street
Landrum, SC 29356
Telephone 864-457-3901

Patient's full name _____ Sex ___ Birthdate _____ Phone _____

Height ____ Weight ____ Social Security No. _____ Marital Status _____

Address: Street _____ City _____ State ____ Zip _____

Occupation _____ Place of Employment _____

Work Phone _____ Dental Insurance Co. _____

Person responsible for account _____ Social Security NO. _____

Address. _____ Phone. (HM) _____ (WK) _____

other family members who are patients _____

**Cell Phone No.** _____

ANSWERS TO THE FOLLOWING QUESTIONS ARE FOR OUR RECORDS ONLY AND WILL BE HELD CONFIDENTIAL !

| | | |
|---|---|---|
| 1. Are you in good health? | YES | NO |
| 2. My last physical examination was on _____ | | |
| 3. Has there been any change in your health within the last year? | YES | NO |
| 4. Are you under the care of a physician? | YES | NO |
| a. If so, what is the condition being treated? _____ | | |
| 5. The name and address of physician _____ | | |
| 6. Have you had any serious illness or operation? | YES | NO |
| a. If so, what was the illness or operation? _____ | | |
| 7. Have you been hospitalized or had a serious illness within the past five years | YES | NO |
| a. If so, what was the nature of the problem _____ | | |
| 8. Have you ever been told you have AIDS or tested HIV+? _____ | YES | NO |
| 9. Do you have or have you had any of the following diseases or problems? | | |
| a. Rheumatic fever or Rheumatic heart disease | YES | NO |
| b. Congenital heart lesions | YES | NO |
| c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency coronary occlusion, high blood pressure, arteriosclerosis, stroke) | YES | NO |
| 1. Do you have chest pain upon exertion | YES | NO |
| 2. Are you ever short of breath after mild exercise | YES | NO |
| 3. Do your ankles swell | YES | NO |
| 4. Do you get short of breath when you lie down, or do you require extra pillows when you sleep | YES | NO |
| d. Allergy, sinus trouble, | YES | NO |
| e. Asthma or hay fever | YES | NO |
| f. Hives or a skin rash | YES | NO |
| g. Fainting spells or seizures | YES | NO |
| h. Diabetes | YES | NO |
| 1. Do you have to urinate (pass water) more than six times a day | YES | NO |
| 2. Are you thirsty much of the time | YES | NO |
| 3. Does your mouth frequently become dry | YES | NO |
| i. Hepatitis, jaundice, or liver disease | YES | NO |
| j. Arthritis | YES | NO |
| k. Inflammatory rheumatism (painful joints) | YES | NO |
| l. Stomach ulcers | YES | NO |
| m. Kidney trouble | YES | NO |
| n. Tuberculosis | YES | NO |
| o. Do you have a persistent cough or cough up blood | YES | NO |

p. Low blood pressure YES NO
q. Swollen glands in the neck YES NO
r. Venereal disease (sexual transmitted disease) YES NO
s. Epilepsy or other neurological disease YES NO
t. Problems with mental health YES NO
U. Cancer or tumor YES NO
V. Problems with immune system YES NO
W. Thyroid problems YES NO

10. Do you use tobacco in any form YES NO
Snuff_____ Cigarettes_____ Cigars/Pipe_____ Chew_____

11. Have you had adnormal bleeding associated with previous extractions, surgery, or trauma YES NO
12. Do you have any blood disorder such as anemia YES NO
13. Do you bruise easily YES NO
14. Have you had x-ray treatment for a tumor, growth, or other condition of the mouth or lips YES NO
15. Are you taking any drug or medicine YES NO
If so, what drug_____
16. Have you ever been told you have glaucoma YES NO
17. Are you taking any of the following:

| | | | | | |
|---|---|---|---|---|---|
| a. Antibiotics or sulfa drugs | YES | NO | b. Anticoagulants | YES | NO |
| c. Medicine for high bld press. | YES | NO | d. Cortisone(steroids) | YES | NO |
| e. Tranquilizers | YES | NO | f. Aspirin | YES | NO |
| g. Insulin,tolbutamide | YES | NO | h. Digatalis or heart medicine | YES | NO |
| i. Nitroglycerin | YES | NO | j. other_____ | YES | NO |

18. Are you allergic or have you reacted adversely to:

| | | | | | |
|---|---|---|---|---|---|
| a. Local Anesthetics | YES | NO | b. PENICILLIN or other antibiotics | YES | NO |
| c. Sulfa drugs | YES | NO | d. Barbiturates, sedatives or sleeping pills | YES | NO |
| e. Aspirin | YES | NO | f. Iodine | YES | NO |
| g. Codeine or other narcotics | YES | NO | h. Other_____ | YES | NO |

19. Have you had any serious trouble associated with any previous dental treatment YES NO
If so, please explain_____
20. Have you had previous periodontal(pyorrhea) treatment YES NO
21. Do you or have you had a bad odor or taste in your mouth YES NO
22. Do you frequently wedge meat or other foods between your teeth YES NO
23. Do you have any teeth which are tender to bitting or pressure YES NO
24. Do you grind or clench your teeth when tired, tense, angry, or asleep YES NO
25. Are your jaw muscles tired or sore when you get up YES NO
26. Are you dissatisfied with the appearance or color of your teeth YES NO
27. How often do you brush your teeth_____
28. Do you use floss and if so how often_____ YES NO
29. Do you have any disease, condition, or problem not listed above that you think we should know about???_____ YES NO
30. Are you employed in any situation which exposes you regulary to X-rays or other forms of radiation? YES NO

WOMEN
31. Are you pregnant or are you nursing YES NO
32. Do you have any problems associated with your menstrual period YES NO
33. Are you taking birth control pills YES NO

OTHER ----- If so, please let us know. We will be happy to care for your dental needs._____

_____

_____

PATIENT SIGNATURE_____