Medical Dental Health Questionnaire

Completing this questionnaire may help begin the process of regaining your health.
Please print this off, complete, and fax to us at 903-825-7155

General Questions:

Do you feel tired often?
Do you have unexplained pain and chronic conditions that you would like to resolve?
Are you currently under the care of a physician? Yes_____ No_____
For:_____
List your 3 major medical/dental complaints/concerns in the order of severity.

1._____
2._____
3._____

Medical Diagnoses you have been given:

1. _____
2. _____
3. _____

What is the major chronic condition(s) you would like to resolve?
_____

What do you believe is the reason for your symptoms and diagnosis?
_____

What do you believe will help you the most to regain and sustain your health?
_____

How long have you been feeling bad?
_____

How long do you think it will take to get well?
_____

Are you experiencing pain?_____

What do you believe is the source of your pain?_____

What is your commitment to getting well?
_____

What is the first thing you believe you need to do?
_____

Are you willing to stop any self-defeating habit or life style to achieve your health goals?
_____

What do you need to stop doing?_____

Specific Questions:

Do you have a current or past diagnosis of Chronic Symptoms or a Chronic Disease?
_____

Have you in the past or currently taking antibiotics for more than two weeks?
_____

What were your dental concerns? Metal___ root canal(s)____jaw infection(s) metal implant(s)_____other____

Have you in the past or currently taking antibiotics for more than two weeks?
_____

Circle teeth which had concerns?
Number from Upper Right to Upper Left 1,2,3,4,5,6,7,8,9,10,12,13,14,15,16
Number from Lower Left to Lower Right 17,18,18,20,21,22,23,24,25,26,27,28,27,30,31,32.

Are you thirsty all the time?_____
How much pure alkaline water do you consume each day?_____

Do you have unexplained pain and/or chronic conditions that you still need resolved?
_____

How many nights do you obtain 8 hours of uninterrupted sleep?
Do you snore?_____ Clench or Grind your Teeth?_____

Do you have daily regular unassisted bowl movements?_____ or Frequent Diarrhea?
_____

Do you have gastro intestinal distress? Bloating?_____ Gas_____How often?
_____

Are you under or over weight?_____By how much?_____
Are you diabetic or have hypoglycemia?_____
Do you have an eating disorder_____

Do you have frequent urination?_____ Incontinence _____ Enlarged Prostrate? _____

Do you have brain fog_____How often?_____

Do you have control of your Autonomic Nervous System (Rest and Digest rather than Fight and Flight)

Do you obtain sufficient sunlight a Vitamin D sources?

Are you always cold?

Do you often have unexplained emotions of sadness, anger or frustration?

Is your temperature generally below normal?

Is your blood pressure abnormally high or low?

Do you have high cholesterol?

Is your Endocrine System functioning; thyroid, adrenals, etc?

Do you have Diagnosed Hypothyroidism or Hyperthyroidism?

Are you mineral deficient? Do you take an Iodine supplement?

Do you drink soda?_____ or eat corn syrup?_____ How Much?_____

Do You Have a Healthy Nutritional Diet?
How often do you eat packaged, prepared and/or fast food or restaurant food?

Do you microwave your food--many restaurants do? _____

Do you smoke or use any type of tobacco?_____ How much_____

Do you drink alcohol? _____ How Much_____

Do you take any prescribed or over the counter medications frequently? _____ How often_____

Do you eat or drink artificial sweeteners?

Do you eat soy?

Do you eat trans fats, canola, soy or corn oils etc.?

Do you have fluoride in your water or use fluoridated toothpaste or products with fluoride?

Do you get at least 20 minutes of daily exercise by walking or using a mini trampoline?

Do you use a microwave?

Do you cook with aluminum cookware or use aluminum foil to wrap your food?

Do you cook with or use plastic wraps/bags with your food?

Do you have environmental toxic exposure such as EMF or Mold etc.?

Do you know if you are dealing with:

a) Cell membrane deficiency
b) Dehydration
c) Hypothyroidism/Iodine Deficiency
d) Heavy Metal Poisoning
e) Thio-ethers from dental caries, root canal tooth, infection in bone
f) Sleep Deprivation

Do you have a healthy diet of raw organic foods that provide the vitamins, minerals, fats, carbohydrates and protein from healthy sources to help your body build healthy cells to replace the unhealthy cells?

Do you have unresolved systemic infections?

What other concerns do you have?

What other concerns have you addressed successfully; i.e., tremors, idiopathic symptoms, epilepsy, arthritis, etc

Have you ever taken any drugs with bisphosphinates?

Do you have difficulty healing from injuries, surgeries, etc?

Do you have additional dental needs? I.e.; sleep study, non-metal implants, invisalign, soft tissue grafting, clenching or grinding appliances, etc.

What dental services have you experienced in this office?

- General Dentistry
- Oral Surgery
- Implants
- Orthodontics
- Soft Tissue Grafting
- Fixed Prostidontics
- Removable Prostidontics

How satisfied are you with your experience in our office overall?

What would you suggest we do to improve?

- Communications
- Scheduling
- Procedures
- Follow up
- Other

How did you hear about our practice?