DR. OCTAVIAN TETELBAUM DENTIST
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Patient questionnaire *In order to provide you with the most appropriate treatment, please complete the following questionnaire.* All information is strictly confidential and for our records only.

Last Name: _____ First Name: _____
Address: _____City/Town:_____
Postal Code: _____ Date of Birth: D_____M_____YR_____Age: _____
Telephone: (_____) _____ Cell: (_____) _____
Work: (_____) _____ Other: (_____) _____
Preference of which number to call you: _____ May we leave a message? Y / N
Email: _____
Emergency Contact: _____Relationship: _____Tel#_____

How were you referred to us? Friend or Family / Facebook / Website / Advertisement / Mail / Physician / Signage / Other: _____

Medical History

Do you have or had any of the following?

AIDS/ HIV	Y / N	Excessive Thirst	Y / N	Phobias	Y / N
Alzheimer's	Y / N	Fainting Spells	Y / N	Psychiatric Care	Y / N
Anaphylaxis	Y / N	Fever Blisters	Y / N	Radiation Treatment	Y / N
Anemia	Y / N	Frequent Diarrhea	Y / N	Recent Weight Loss	Y / N
Angina	Y / N	Frequent Headaches	Y / N	Recent Weight Gain	Y / N
Anxiety	Y / N	Genital Herpes	Y / N	Renal Dialysis	Y / N
Arthritis	Y / N	Glaucoma	Y / N	Rheumatic Fever	Y / N
Artificial Heart Valve	Y / N	Gout	Y / N	Rheumatism	Y / N
Artificial Joints	Y / N	Hay Fever	Y / N	Scarlet Fever	Y / N
Asthma	Y / N	Heart Attack/ Failure	Y / N	Shingles	Y / N
Blood Disease	Y / N	Heart Pacemaker	Y / N	Sickle Cell	Y / N
Blood Transfusion	Y / N	Heart Trouble/Disease	Y / N	Sinus Infections /Trouble	Y / N
Breathing Problems	Y / N	Hemophilia	Y / N	Spina Bifida	Y / N
Bruise Easily	Y / N	Hepatitis A, B, C	Y / N	Stomach Disease	Y / N
Cancer	Y / N	High Blood Pressure	Y / N	Stroke	Y / N
Chemotherapy	Y / N	HPV	Y / N	Swelling of Limbs	Y / N
Chest Pains	Y / N	Immunocompromized	Y / N	Thyroid Disease	Y / N
Cold Sores	Y / N	Insomnia	Y / N	Tonsillitis	Y / N
Congenital Heart Disorder	Y / N	Intestinal Disease	Y / N	Tuberculosis	Y / N
Convulsions	Y / N	Jaundice	Y / N	Tumors / Growths	Y / N
Cortisone Medicine	Y / N	Lung Disease	Y / N	Ulcers	Y / N
Diabetes	Y / N	Mitral Valve Prolapse	Y / N	Venereal Disease	Y / N
Depression	Y / N	Muscle Cramps	Y / N	Vertigo	Y / N
Dizziness	Y / N	Motor Vehicle Accident	Y / N	Other: _____	
Drug Addiction	Y / N	Nausea	Y / N		
Easily Winded	Y / N	Nervousness	Y / N	Women Only :	
Emphysema	Y / N	Pain in Jaw Joints	Y / N	Pregnant?	Y / N
Epilepsy/Seizures	Y / N	Panic Attacks	Y / N	Trying to get Pregnant?	Y / N
Excessive Bleeding	Y / N	Parathyroid Disease	Y / N	Taking Birth Control?	Y / N

Personal Habits or Occurrences

Chew gum?	Y / N	In Past / Currently	Per Day / Week: _____
Eat Candy?	Y / N	In Past / Currently	Per Day / Week: _____
Consume Soft Drinks?	Y / N	In Past / Currently	Per Day / Week: _____
Consume Coffee?	Y / N	In Past / Currently	Per Day / Week: _____
Consume Alcohol?	Y / N	In Past / Currently	Per Day / Week: _____
Smoke Cigarettes?	Y / N	In Past / Currently	Per Day / Week: _____
Smoke Cigars/ Other?	Y / N	In Past / Currently	Per Day / Week: _____
Suck on Thumb/fingers?	Y / N	In Past / Currently	Per Day / Week: _____
Bite Nails/Other(ie. pens)?	Y / N	In Past / Currently	Per Day / Week: _____
Wake up Tired?	Y / N	In Past / Currently	Per Week / Mth: _____
Low Energy During Day?	Y / N	In Past / Currently	Per Week / Mth: _____
Trouble Concentrating?	Y / N	In Past / Currently	Per Week / Mth: _____
Do you wear a Night guard	Y / N	In Past / Currently	Per Week / Mth: _____
Do you use a CPAP for Sleep	Y / N	In Past / Currently	Per Week / Mth: _____
Wake Often During Sleep?	Y / N	Times per sleep: _____	Avge Hours of Sleep per night _____

Are there any other habits we should be aware of? Y / N If Yes, Please Explain: _____
_____

How many glasses of water do you consume per day on average? _____
How often are you involved in exercise per week? _____ What activities? _____
Please describe to us your eating habits on a daily basis: _____
_____
_____
_____
List out your medications/ vitamins consumed. Include dose and frequency: _____
_____
_____
_____

Are you under a Physician's care now? Y / N If Yes, Please Explain: _____
Hospitalized or had Major Operations? Y / N If Yes, Please Explain: _____
Serious Head or Neck Injury? Y / N If Yes, Please Explain: _____
Taking any Medications, Pills, Drugs? Y / N If Yes, Please Explain: _____
_____
_____

Are you on a Special Diet? Y / N If Yes, Please Explain: _____
Do you have any Allergies Y / N If Yes, Please Explain: _____
_____
_____

Synergy / Doctor Notations Only:
_____
_____
_____
_____
_____

Musculoskeletal Screening

Pain in Jaw and Joints? __ L R __

Pain in ear? __ L R __

Pain around eyes? __ L R __

Pain in lower jaw? __ L R __

Pain in upper jaw? __ L R __

Pain in neck? __ L R __

Pain in shoulder? __ L R __

Pain in forehead? __ L R __

Pain in temples? __ L R __

Pain in facial muscles? __ L R __

Grating sound in joint? __ L R __

Subjective hearing loss? __ L R __

Clicking, snapping, popping sound in joint? __ L R __

Ringing in ears? __ L R __

Fullness or, pressure blockage in ear? __ L R __

Pain in tongue? Y / N

Limited Mouth Opening? Y / N
If yes, Partially? Severe?
If yes, Constant? Sporadic?

Difficulty chewing? Y / N

Change in chewing? Y / N

Difficulty swallowing? Y / N

Change in swallowing? Y / N

Snoring? Y / N

Constantly tired? Y / N

Mouth Breathe at night? Y / N

Awaken with a dry mouth? Y / N
If yes, Frequently? Rarely?

Tingling in Finger Tips? Y / N

Postural Problems? Y / N

History of Clenching Teeth? Y / N

History of Grinding Teeth? Y / N

Loose Teeth? Y / N

Sensitive Teeth? Y / N
If yes, Constant? Sporadic?
If yes, Hot? Cold? Other?

To the best of my knowledge, the Questions on this form have been accurately answered.

I,_____ understand that providing incorrect information can be dangerous to my health.

I, _____ recognize it is my responsibility to inform Synergy Centre of any changes to my medical history or personal lifestyle that may or may not be relevant to the care received by any of the doctors, or team members of Synergy Centre. I understand that I am encouraged to ask as many questions as required in order for me to decide the course of care I decide to go forward with.

Patient's Printed Name: _____Patient's Signature: _____

Date: _____ Treatment Co/ordinator: _____

Dentist/ Dental Team Notations Only:

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