PRE-APPOINTMENT ORAL HEALTH INFORMATION: PREGNANT WOMAN

Patient Information

Patient's Name _____

Primary Phone Number _____

Alternate Phone Number _____

Medical Doctor or Clinic Name _____

Physician phone number _____

Pregnancy Information

How far along are you in your pregnancy?		
When is your baby due?		
Have you had problems with nausea/vomiting?	YES	NO

Reason for Appointment

Regular dental checkup	YES	NO
Dental cleaning-Prophylaxis	YES	NO
Dental concern: Pain Swelling Bleeding Broken tooth		

Current Medication

Name:	Dose:	Frequency:
Name:	Dose:	Frequency:

Comfort

Need extra support (circle all that apply): Head Neck Back Arms Knees Feet		
Can recline in dental chair	YES	NO
Needs blanket or security support/pillows	YES	NO

Habits

Do to brush your teeth every day?	YES	NO
Do you maintain a healthy diet?	YES	NO
Do you drink sweetened beverages daily?	YES	NO
Do you eat candy or other sweet snacks daily?	YES	NO
Use of Tobacco: Cigarettes Chewing	YES	NO

Patient Concerns

Gag reflex	YES	NO
Trouble swallowing	YES	NO
Anxiety issues	YES	NO
If yes, please explain:		

Additional information

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