Name:_____ Date:_____

Anxiety Sensitivity Index

Please rate each item by selecting one of the five answers for each question. Please answer each statement by circling the number that best applies to you.

	very little	a little	some	much	very much
1. It is important not to appear nervous.	0	1	2	3	4
2. When I cannot keep my mind on a task, I worry that I might be going crazy.	0	1	2	3	4
3. It scares me when I feel shaky.	0	1	2	3	4
4. It scares me when I feel faint.	0	1	2	3	4
5. It is important to me to stay in control of my emotions.	0	1	2	3	4
6. It scares me when I my heart beat rapidly.	0	1	2	3	4
7. It embarrasses me when my stomach growls.	0	1	2	3	4
8. It scares me when I am nauseous (sick stomach).	0	1	2	3	4
9. When I notice my heart beating rapidly, I worry that I might be having a heart attack.	0	1	2	3	4
10. It scares me when I become short of breath.	0	1	2	3	4
11. When my stomach is upset, I worry that I might be seriously ill.	0	1	2	3	4
12. It scares me when I am unable to keep my mind on a task.	0	1	2	3	4
13. Other people notice when I feel shaky.	0	1	2	3	4
14. Unusual body sensations scare me.	0	1	2	3	4
15. When I am nervous, I worry that I might be mentally ill.	0	1	2	3	4
16. It scares me when I am nervous.	0	1	2	3	4

PLEASE CONTINUE ON OTHER SIDE

Name:_____ Date:_____

GETZ DENTAL BELIEFS SURVEY

The items in this questionnaire refer to various situations, feelings, and reactions related to dental work. Please rate your feelings or beliefs on these items by circling the number (1,2,3,4,or 5) of the category which most closely correspondents to your feelings about **dentistry in general**.

		never	once or twice	a few times	often	nearly always
1	I am concerned that dentists recommend work that is not really needed.	1	2	3	4	5
2	I believe dentists say/do things to withhold information from me.	1	2	3	4	5
3	I worry if the dentist is technically competent and is doing quality work.	1	2	3	4	5
4	I have had dentists say one thing and do another.	1	2	3	4	5
5	I am concerned that dentists provide all the information I need to make good decisions.	1	2	3	4	5
6	Dentists don't seem to care that patients sometimes need a rest.	1	2	3	4	5
7	I've had dentists seem reluctant to correct work unsatisfactory to me.	1	2	3	4	5
8	When a dentist seems in a hurry I worry that I'm not getting good care.	1	2	3	4	5
9	I am concerned that the dentist is not looking out for my best interests	1	2	3	4	5
10	Dentists focus too much on getting the job done and not enough on the patient's comfort.	1	2	3	4	5
11	I'm concerned that dentists might not be skilled enough to deal with my fears or dental problems.	1	2	3	4	5
12	I feel dentists do not provide clear explanations.	1	2	3	4	5
13	I am concerned that dentists do not like to take the time to really talk to patients.	1	2	3	4	5
14	I feel uncomfortable asking questions.	1	2	3	4	5
15	Dental professionals say things to make me feel guilty about the way I care for my teeth.	1	2	3	4	5
16	I am concerned that dentists will not take my worries (fears) about dentistry seriously.	1	2	3	4	5
17	I am concerned that dentists will put me down (make light of my fears).	1	2	3	4	5
18	I am concerned that dentists do not like it when a patient makes a request.	1	2	3	4	5
19	I am concerned that dental personnel will embarrass me over the condition of my teeth.	1	2	3	4	5
20	I believe that dentists don't have enough empathy for what it is really like to be a patient.	1	2	3	4	5

PLEASE CONTINUE ON OTHER SIDE

Name:_____ Date:_____

		never	once or twice	a few times	often	nearly always
21	When I am in the chair I don't feel like I can stop the appointment for a rest if I feel the need.	1	2	3	4	5
22	Dentists don't seem to notice that patients sometimes need a rest.	1	2	3	4	5
23	Once I am in the chair I feel helpless (that things are out of my control).	1	2	3	4	5
24	If I were to indicate that it hurts, I think that the dentist would be reluctant to stop and try to correct the problem.	1	2	3	4	5
25	I have had dentists not believe me when I said I felt pain.	1	2	3	4	5
26	Dentists often seem in a hurry, so I feel rushed.	1	2	3	4	5
27	I am concerned that the dentist will do what he wants and not really listen to me while I'm in the chair.	1	2	3	4	5
28	Being overwhelmed by the amount of work needed (all the bad news) could be enough to keep me from beginning or completing treatment.	1	2	3	4	5

TOTAL: ____

Name:_____ Date:_____

Please pick the best answer for each question by circling the word or phrase.

1. How concerned are you about not being able to prevent something which might cause you pain?	**Not At All**	**Very Little**	**Somewhat**	**Very Much**	**Extremely**
2. To what degree would you like control over what will happen to you in the dental chair?	**None**	**Very Little**	**Some**	**Very Much**	**Total Control**
3. How much control would you like to have over the events that will occur during your dental treatment?	**Never**	**Very Little**	**Some**	**Very Much**	**Total**
4. Do you feel you have control of what will happen to you while in the dental chair?	**None**	**Rarely**	**Occasionally**	**Frequently**	**Always**
5. How much do you think you can control what will happen to you while in the dental chair?	**None**	**Very Little**	**Some**	**Very Much**	**Total**
6. In general, how much control would you like to have over what will happen during your dental treatment?	**None**	**Very Little**	**Some**	**Very Much**	**Total**
7. In general, how much control do you feel you have over what will happen during your dental treatment?	**None**	**Very Little**	**Some**	**Very Much**	**Total**
8. How much control would you like to have over your negative thoughts during your dental procedure?	**None**	**Very Little**	**Some**	**Very Much**	**Total**
9. How much do you think you can control your negative thoughts during dental treatment?	**None**	**Very Little**	**Some**	**Very Much**	**Total**

Name:_____ Date:_____

DENTAL COGNITIONS CHECKLIST

Each item below describes a thought that some patients think to themselves aboutdental care. Please read each statement and indicate the degree to which it applies to you now.

I think that...

	Choose the answer closest to true where statement is not fully applicable.	Don't know	Not at all	Rarely	Sometimes	Often	Extremely
1	the needle seems so long! Like it could stick into my eye, nose, or brain.						
2	the needle might hit a nerve or something and damage it.						
3	nothing is as painful as a needle in my mouth.						
4	the needle might break off.						
5	medical needles are much smaller and less painful.						
6	I'm very hard to get numb.						
7	if my throat gets numb from a shot I won't be able to breathe or swallow.						
8	if I'm leaned back too far in the dental chair I get claustrophobic.						
9	when I'm in the dental chair I can't stop for a rest.						
10	being in the dental chair can bring back bad memories from other events in my life.						
11	I can't breathe with a rubber dam.						
12	I can't swallow with a rubber dam.						
13	I might get too much radiation from the X-rays.						
14	the mercury or other metals (or plastics) might be dangerous to my health						
15	too much topical anesthetic might make it so I could not breathe or swallow.						
16	I'm always waiting for the drill to hurt me.						
17	I'm fearful that the dentist might slip and injure me.						
18	I can't stand the sound of the drill.						
19	I can't stand the sound of having my teeth cleaned (scraped).						
20	I can't stand that burning smell when they drill on teeth.						

PLEASE CONTINUE ON OTHER SIDE

Name:_____ Date:_____

		Don't know	Not at all	Rarely	Sometimes	Often	Extremely
21	I'm allergic to something-like Novocain, and it might harm me.						
22	impressions (molds and models) make me feel like I can't swallow or breathe.						
23	impressions (molds and models) make me feel like I will gag.						
24	X-rays make me gag.						
25	X-rays hurt.						
26	I will have lots of pain after treatment						
27	they will find something terrible and wrong with me.						
28	I might be so scared I will do something embarrassing.						
29	it is so embarrassing to be fearful, I might not go ahead with treatment.						
30	I get anxious before a dental appointment.						
31	I am emotionally exhausted after an appointment.						
32	I am physically exhausted after an appointment.						
33	I can't stand the sight or taste of blood.						
34	they might drill too deep						
35	the dentist is going to say I need a root canal.						
36	I'll lose all my teeth.						
37	the numbness will not go away.						
38	the dentist will think I'm foolish or childish.						
39	I feel so guilty about letting things go, I don't deserve treatment.						
40	I'm so fearful that I'm too much trouble to treat.						
	Did we miss any? Please write down any anxiety provoking or disturbing thoughts you might have relating to dental care						
41							
42							
43							

Name:_____ Date:_____

DENTAL REPORT

The items in this questionnaire refer to various situations, feelings, and reactions related to dental work. Please rate your feeling or reaction about these items by *circling the number* (1, 2, 3, 4, or 5) of the category which most closely corresponds.

		never	once or twice	a few times	often	nearly always
1.	Has fear of dental work ever caused you to put off making an appointment?	1	2	3	4	5
2.	Has fear of dental work ever caused you to cancel or not appear for an appointment?	1	2	3	4	5

When having dental work done . . .

3.	my muscles become tense.	1	2	3	4	5
4.	my breathing rate increases.	1	2	3	4	5
5.	I perspire.	1	2	3	4	5
6.	I feel nauseated and sick to my stomach.	1	2	3	4	5
7.	my heart beats faster.	1	2	3	4	5
8.	I seriously gag.	1	2	3	4	5
9.	I have difficulty breathing.	1	2	3	4	5

Following is a list of things and situations that many people mention as being somewhat anxiety or fear producing. Please rate how much fear, anxiety, or unpleasantness each of them causes you by *circling the number* (1, 2, 3. 4, or 5) of the category which most closely corresponds. (If it helps, try to imagine yourself in each of these situations and describe what your typical reaction is.)

		none	a little bit	some	quite a bit	very much
10.	Making an appointment for dentistry.	1	2	3	4	5
11.	Approaching the dentist's office.	1	2	3	4	5
12.	Sitting in the waiting room.	1	2	3	4	5
13.	Being seated in the dental chair.	1	2	3	4	5
14.	The smell of the dentist's office.	1	2	3	4	5
15.	Seeing the dentist walk in.	1	2	3	4	5
15.	Seeing the anesthetic needle.	1	2	3	4	5
17.	Feeling the needle injected.	1	2	3	4	5
18.	Seeing the drill.	1	2	3	4	5
19.	Hearing the drill.	1	2	3	4	5
20.	Feeling the vibrations of the drill.	1	2	3	4	5
21.	Having my teeth cleaned.	1	2	3	4	5
22.	All things considered, how fearful are you of having dental work done?	1	2	3	4	5

NAME: _____ DATE: _____ CHART: _____

UNIVERSITY OF WASHINGTON SCHOOL OF DENTISTRY - MEDICAL AND DENTAL HISTORY

GENERAL INFORMATION

1. a. **Date of Birth:** ____ ____ ____ (Month Day Year) b. **Gender:** ○ **Male** ○ **Female** c. **Weight:** _____ lbs. d. **Height:** _____ ft. _____ inches

e. **Highest grade of regular school that you have completed?** _____ f. **Employed?** ○ Yes ○ No

GENERAL MEDICAL INFORMATION

2. Please rate your health. ○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor

3. Has there been a change in your general health in the past year? ○ Yes ○ No

4. Your Physician:_____City_____ Phone No.: _____

5. Date of last physical examination: Month _____Year _____ Currently under treatment by a physician? ○ Yes ○ No

Please explain_____

6. Do you engage in regular exercise? ○ Yes ○ No Type_____

7. **Do you need to take antibiotics prior to receiving dental or surgical care?** ○ **Yes** ○ **No** ○ **Don't know**

MAJOR HOSPITALIZATIONS, SURGERIES, AND BLOOD TRANSFUSION → ○ MARK HERE IF NONE ○ VERIFIED BY EXAMINER

8. **DATE (Month/Year)** **REASON**

_____

_____

_____

_____

_____

ALLERGIC OR UNUSUAL REACTION TO ANY OF THE FOLLOWING? → ○ MARK HERE IF NONE ○ VERIFIED BY EXAMINER

9. ○ Penicillins ○ Opiates/codeine ○ Other drugs: ○ Other substances (food, metals, etc.)
○ Sulfa drugs ○ Iodine List: 1. _____ List: 1. _____
○ Aspirin ○ Latex 2. _____ 2. _____
○ Local anesthesia 3. _____ 3. _____

Type of Reaction _____

WOMEN ONLY ○ NOT APPLICABLE

10. **Are you** ○ **PREGNANT?** _____ weeks? ○ Trying to become pregnant? ○ Not sure if you are pregnant?
○ Using birth control pills _____ (Name of Prescription) ○ Going through menopause? ○ Post-menopausal?

PRESCRIPTION/ NON PRESCRIPTION MEDICATIONS → ○ MARK HERE IF NONE ○ VERIFIED BY EXAMINER
(Use continuation page if necessary)

11. List all medications and herbal supplements/remedies that you are currently taking.

Name:	For what Condition?	Dose/Frequency of use:
A)		
B)		
C)		
D)		
E)		
F)		

GENERAL MEDICAL INFORMATION - PRESENT SYMPTOMS

12. Mark symptom(s) that you NOW experience or HAVE RECENTLY experienced. → ○ MARK HERE IF NONE ○ VERIFIED BY EXAMINER

GENERAL
- ○ Weight loss_____ Lbs. Over what time period? _____
- ○ Weight gain_____ Lbs. Over what time period? _____
- ○ Loss of appetite _____
- ○ Always hungry _____
- ○ Always thirsty _____
- ○ Frequent urination_____
- ○ Fatigue _____
- ○ Faint easily _____
- ○ Night sweats_____
- ○ Bleed easily _____
- ○ Bruise easily_____

CARDIOVASCULAR
- ○ Shortness of breath with exertion_____
- ○ Racing or irregular heart beat_____
- ○ Swollen ankles _____
- ○ Cold ankles/feet _____
- ○ Chest pain/angina_____

RESPIRATORY
- ○ Coughing spell_____
- ○ Wheezing_____
- ○ Use 2 or more pillows to sleep_____

MUSCULOSKELETAL
- ○ Joint pain _____
- ○ Swollen joints _____
- ○ Muscle cramping_____

SKIN CHANGES
- ○ Skin problems_____
- ○ Nail changes_____

NEUROLOGICAL
- ○ Numbness/tingling_____
- ○ Paralysis/weakness_____
- ○ Memory changes_____
- ○ Smell/taste changes_____
- ○ Difficulty chewing_____
- ○ Swallowing changes_____
- ○ Speech changes_____
- ○ Dizzy spells or fainting_____

GASTROINTESTINAL
- ○ Indigestion _____
- ○ Reflux/heartburn_____
- ○ Nausea/vomiting_____
- ○ Bowel problems_____

HEAD & NECK
- ○ Neck pain_____
- ○ Neck lump/swelling_____
- ○ Headache_____
- ○ Facial pain _____
- ○ Jaw pain_____

SALIVARY
- ○ Need liquid to swallow dry foods_____
- ○ Mouth feels dry when eating a meal_____
- ○ Difficulties swallowing any foods_____
- ○ Sense of too little saliva_____
- ○ Sense of too much saliva_____

EYES
- ○ Vision changes_____
- ○ Dry eyes_____

EARS
- ○ Hearing loss_____
- ○ Ringing ears_____
- ○ Earaches _____
- ○ Pressure/stuffiness in ears_____

NOSE/THROAT
- ○ Congested/runny nose_____
- ○ Nose bleeds _____
- ○ Nasal obstruction _____
- ○ Sore throat _____
- ○ Hoarseness/voice changes _____
- ○ Mouth breathing/ snoring _____

PAIN
- ○ Back pain_____
- ○ Other pains _____

BEHAVIORAL
- ○ Stress_____
- ○ Sleep difficulties_____
- ○ Feel depressed _____
- ○ Feel agitated/anxious_____
- ○ Other _____

FAMILY MEDICAL HISTORY

○ MARK HERE IF NO ONE IN YOUR FAMILY HAS *EVER* HAD ANY OF THE PROBLEMS LISTED BELOW ○ VERIFIED BY EXAMINER:

13. Darken the circle beside medical problems that have been present in your parents, brothers/sisters, or close relatives.

- ○ Genetic (inherited) disease _____
- ○ Liver/kidney disease_____
- ○ Immune system disease _____
- ○ Diabetes_____
- ○ Bleeding disorders _____
- ○ Tuberculosis_____
- ○ Neurologic disease_____
- ○ Other (include cancer)_____

MEDICAL HISTORY - PAST AND PRESENT ILLNESS

14. **Darken the circle for illnesses that you CURRENTLY HAVE or HAVE HAD IN THE PAST**

○ **MARK HERE IF NONE**
○ **VERIFIED BY EXAMINER**

Cancer & Neoplastic Disease
- ○ Cancer_____
- ○ Leukemia/Lymphoma _____

Genetic (inherited) Disease
- ○ Type_____

Immune System Disorder
- ○ Rheumatoid arthritis_____
- ○ Lupus erythematosus_____
- ○ Sjogren's Syndrome_____
- ○ Other_____

Hormonal or Metabolic Disorders
- ○ Diabetes_____
- ○ Thyroid problems _____
- ○ Adrenal insufficiency_____
- ○ Other_____

Heart/Blood Disorders
- ○ High blood pressure_____
- ○ Artherosclerosis_____
- ○ Heart attack _____
- ○ Coronary artery disease_____
- ○ Heart murmur_____
- ○ Heart valve problems_____
- ○ Bleeding disorder_____
- ○ Anemia_____
- ○ Other _____

Neurological Disorders
- ○ Epilepsy/Seizures_____
- ○ Neuralgia _____
- ○ Stroke_____
- ○ Other_____

Chronic Pain
- ○ Back _____
- ○ Abdominal_____
- ○ Headache/Migraine _____
- ○ Other_____

Head and Neck Conditions
- ○ Injury to face, jaws, neck _____
- ○ Concussion_____
- ○ Radiation treatment _____
- ○ Temporomandibular joint disease _____
- ○ Salivary gland problems_____
- ○ Sinusitis _____
- ○ Glaucoma_____
- ○ Other _____

Gastrointestinal Disorders
- ○ Acid-reflux /Heartburn_____
- ○ Ulcer/Gastritis_____
- ○ Irritable bowel syndrome/Colitis _____
- ○ Other_____

Lung/Airway Disorders
- ○ Emphysema_____
- ○ Pneumonia_____
- ○ Bronchitis_____
- ○ Asthma_____
- ○ Tuberculosis_____
- ○ Sleep Apnea_____
- ○ Other_____

Skin Disorders
- ○ Skin cancer_____
- ○ Skin infections _____
- ○ Other_____

Other Major Organ Disease
- ○ Kidney disease_____
- ○ Liver disease_____
- ○ Organ transplant_____
- ○ Spleen surgery_____
- ○ Other _____

Infectious Diseases
- ○ Rheumatic fever_____
- ○ Strep Throat_____
- ○ Mononucleosis_____
- ○ Hepatitis_____
- ○ Sexually-transmitted diseases_____
- ○ HIV/AIDS _____
- ○ Other_____

Behavioral Conditions
- ○ Psychiatric illness_____
- ○ Anxiety/Panic attacks_____
- ○ Depression_____
- ○ Suicide attempt or thoughts _____
- ○ Other_____

Habits/Addiction
- ○ Drug abuse_____
- ○ Alcohol abuse_____

Other Conditions
- ○ Disabled _____
- ○ Prosthetic valve _____
- ○ Prosthetic joint _____

DOCTOR'S/ STUDENT'S USE

(Please write comments about positive responses on lines adjacent to item and use this space as needed):

15. **CONSUMPTION OF BEVERAGES AND OTHER SUBSTANCES** → ○ **MARK HERE IF NONE** ○ **VERIFIED BY EXAMINER**

a. Number of caffeinated beverages you drink in a day:
○ 0 ○ 1-2 ○ 3-5 ○ 5+

b. Number of alcoholic beverages you drink in a week:
○ 0 ○ 1-2 ○ 3-5 ○ 6-10 ○ 10+

d. Number of carbonated beverages a day:
○ 0 ○ 1-2 ○ 3-5 ○ 5+

c. Currently using any street or recreational drugs?
○ No ○ Yes (Type?)_____

e. Have you ever used tobacco? ○ No ○ Yes
If yes, what type:
○ Cigarette ○ Pipe/Cigar ○ Smokeless

f. Do you currently use tobacco? ○ No ○ Yes
If yes, average number of uses per day: _____
For how many years? _____

16. **DENTAL HISTORY : Darken the circle beside items that describe your past dental problems and dental care.**

○ Regular dental care
○ Occasional dental care
○ Wisdom tooth extractions
○ Orthodontics
○ Gum disease (pyorrhea, gingivitis or periodontal disease)
○ Treatment for jaw trauma/fracture (Type?)_____
○ Had an adverse reaction to dental treatment (Please describe)_____
○ Dental fears or anxiety_____

17. Rate your ORAL HEALTH in general. ○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor

18. How good a job do you feel you are doing in taking care of your oral health?
○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor

19. Date of last regular dental visit: ____ ____ Name and address of dentist: _____
Month Year
_____
_____

FAMILY DENTAL HISTORY

20. Darken the circle beside oral problems that have been present in your parents, brothers/sisters, or close relatives.
○ Caries ○ Gum disease (pyorrhea, gingivitis or periodontal disease) ○ Dry Mouth ○ TMJ disorder

DOCTOR'S/ STUDENT'S USE

Additional Notes or Comments:

Patient's Signature_____ **Date**_____

Reviewed by (Student)_____
Date_____

Reviewed by (Faculty) _____
Date_____