

HEALTH QUESTIONNAIRE

In the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

Name _____ Sex _____ Age _____ Date of Birth _____

Address _____ City _____ Zip Code _____

Phones: Res. _____ Bus. _____ Height _____ Weight _____

Cell Phone _____ Email _____

Today's Date _____ Place of Employment _____ Marital Status _____

Social Security # _____ Dental Ins. No ___ Yes ___ Name _____

Name of Spouse _____ or Closest Relative _____ Ph _____

General Dentist _____

- YES NO 1. Are you in good health?
- YES NO 2. Has there been any change in your general health within the past year?
3. My last physical examination was on _____
- YES NO 4. Are you now under the care of a physician?
- a. If so, what is the condition being treated? _____
5. The name and address of my physician is _____
- _____
- _____
- YES NO 6. Have you had any serious illness or operation?
- a. If so, what was the illness or operation? _____
- YES NO 7. Are you worried about receiving dental treatment?
- YES NO 8. Have you had any serious trouble associated with any previous dental treatment?
- If so, explain _____
- YES NO 9. Are you taking any drug or medicine?
- If so, what? _____
10. Are you allergic or have you reacted adversely to:
- YES NO 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 11. Have you ever been told to premedicate with an antibiotic for dental procedures?
- YES NO 12. Do you have any implants? eg. breast, vascular blood vessels, etc.
- YES NO 13. Have you had any joint replacement surgery? eg. hip, finger, knee, etc.
14. Do you have or have you had any of the following diseases or problems?
- YES NO a. Heart murmur; damaged heart valves, or artificial heart valves, mitral valve prolapse, congenital heart lesions.
- YES NO b. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, high blood pressure, arteriosclerosis, stroke)
- 1) Do you have pain in chest 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 5) Do you have a cardiac pacemaker?
- YES NO 6) Have you ever had Rheumatic Fever?

- YES NO c. Allergy
- YES NO d. 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 swollen 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. Venereal disease
- YES NO r. AIDS - HIV
- YES NO s. Other _____
- YES NO 15. Have you had abnormal bleeding associated with previous extractions, surgery or trauma?
- YES NO a. Do you bruise easily?
- YES NO b. Have you ever required a blood transfusion?
- If so, explain the circumstances _____
- YES NO 16. Do you have any blood disorder such as anemia?
- YES NO 17. Have you had surgery or x-ray treatment for a tumor, growth, or other condition on your head or neck?
- YES NO 18. Do you have any disease, condition, or problem not listed above that you think I should know about?
- If so, explain _____

WOMEN

- YES NO 19. Are you pregnant?
- YES NO 20. Do you have any problems associated with your menstrual period?
- YES NO 21. Are you nursing?

CHIEF DENTAL COMPLAINT: _____

WEST MICHIGAN PERIODONTICS

I authorize for release of information and assignment of benefits relating to my dental / medical insurance.

 SIGNATURE OF PATIENT