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, congential heart lesions.
YES NO b. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, high blood pressure, arteriosclerosis, stroke)
YES NO 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?

OVER

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
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, expain 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 _____
_____

CHIEF DENTAL COMPLAINT: _____
_____
_____
_____

19. **HEALTH CHANGES:**

DATE: _____
_____
DATE: _____
_____
DATE: _____
_____
DATE: _____
_____

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

_____

SIGNATURE OF PATIENT DATE