HEALTH QUESTIONNAIRE

RECORD NO. _____

NAME _____ DATE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____ HOME PHONE NO. _____ CELL PHONE NO. _____

SOCIAL SECURITY NO. _____ DRIVER'S LICENSE NO. _____ STATE _____

PHYSICIAN _____ PHONE NO. _____

EMPLOYER _____ EMPLOYER PHONE NO. _____

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT PRESENT:

HEART TROUBLE
IRREGULAR HEAT BEAT
CONGESTIVE HEART FAILURE
HEART MURMUR
RHEUMATIC FEVER
MITRAL VALVE PROLAPSE
HEART SURGERY
HEART PACEMAKER
ARTIFICIAL HEART VALVE
CONGENITAL HEART PROBLEMS
STROKE
EMPHYSEMA
LUNG PROBLEMS

HIGH OR LOW BLOOD PRESSURE
DIABETES
LOW SUGAR
PERSISTENT COUGH
THYROID DISEASE
HEPATITIS
YELLOW JAUNDICE
LIVER DISEASE
VENEREAL DISEASE
CANCER OR TUMORS
X-RAY OR COBALT TREATMENTS
CHEMOTHERAPY

ANEMIA OR BLOOD DISEASE
ULCERS
ALLERGIES
KIDNEY TROUBLE
HEMODIALYSIS
ARTHRITIS
ASTHMA
RHEUMATISM
CONTACT LENSES
ARTIFICIAL JOINTS - PINS OR POST
STEROIDS (CORTISONE)
DRUG ADDICTION
EPILEPSY

MENTAL HEALTH PROBLEMS
TUBERCULOSIS
HEMOPHILIA
HEADACHES
AIDS OR HIV
HERPES INFECTION
EASY TO BRUISE
VASCULAR SURGERY
SINUS TROUBLE
EYE SURGERY
CATARACTS
GLAUCOMA
WEIGHT _____
TAKE ASPIRIN DAILY

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1. HAVE YOU BEEN UNDER A PHYSICIAN'S CARE DURING THE PAST TWO YEARS? ..... YES NO

2. ARE YOU TAKING ANY MEDICATIONS (DRUGS) NOW? ..... YES NO
   IF SO, PLEASE LIST: _____
   _____

3. ARE YOU OR HAVE YOU EVER TAKEN ANY DRUGS FOR CANCER OR OSTEOPEROSIS? ..... YES NO

4. DO YOU TAKE ASPIRIN, MOTRIN OR TYLENOL? ..... YES NO
   ☐ DAILY ☐ OFTEN

5. DO YOU PREMED WITH ANTIBIOTICS FOR DENTAL APPOINTMENTS? ..... YES NO

6. HAVE YOU EVER BLED EXCESSIVELY AFTER AN INJURY OR TOOTH EXTRACTION? ..... YES NO

7. DO YOU EVER HAVE PAIN IN YOUR CHEST UPON EXERTION? ..... YES NO

8. ARE YOU EVER SHORT OF BREATH AFTER MILD EXERTION? ..... YES NO

9. HAS THERE BEEN ANY CHANGE IN YOUR GENERAL HEALTH IN THE LAST YEAR? ..... YES NO

10. DO YOUR ANKLES SWELL? ..... YES NO

11. WOMEN: ARE YOU PREGNANT NOW? (PLEASE ANSER YES IF YOU ARE NOT SURE) ..... YES NO
    ARE YOUR TAKING BIRTH CONTROL PILLS? ..... YES NO
    DO YOU ANTICIPATE BECOMING PREGNANT? ..... YES NO
    ARE YOU A NURSING MOTHER? ..... YES NO

12. DO YOU HAVE ANY NASAL OBSTRUCTION? ..... YES NO

13. HAVE YOU HAD DENTAL X-RAYS MADE IN THE LAST YEAR? ..... YES NO

14. HAVE YOU EVER HAD AN INJURY TO YOUR FACE OR JAWS? ..... YES NO

15. HAVE YOU EVER FAINTED IN THE DENTAL OFFICE? ..... YES NO

16. DO YOU USE ALCOHOL? ..... YES NO
    DAILY? ..... YES NO

(CONTINUED ON BACK PAGE)

17. DO YOU USE TOBACCO IN ANY FORM? ..... YES NO

☐ CHEW ☐ DIP ☐ CIGARETTES ☐ CIGARS ☐ PIPE

18. DO YOU HAVE A COLD OR RESPIRATORY INFECTION NOW? ..... YES NO

19. DO YOU HAVE PERSISTENT DIARRHEA OR RECENT WEIGHT LOSS? ..... YES NO

20. HAVE YOU EVER HAD A REACTION TO DENTAL ANESTHETIC? ..... YES NO

21. DO YOU HAVE AN ALLERGY TO LATEX? ..... YES NO

22. DESCRIBE ANY MEDICAL CONDITIONS YOU HAVE THAT ARE NOT ON THIS FORM

_____

_____

_____

23. LIST ANY DRUGS TO WHICH YOU ARE ALLERGIC (SULPHUR, PENICILLIN, TETRACYCLINE, ASPIRIN, CODEINE):

_____

24. HAS ANY PHYSICIAN TOLD YOU THAT YOU HAVE A CONDITION OR SITUATION FOR WHICH YOU SHOULD TAKE ANTIBIOTICS BEFORE DENTAL TREATMENT?

_____

25. **WHAT IS YOUR CHIEF DENTAL COMPLAINT?**

_____

_____

_____

IF I HAVE ANY CHANGE IN MY HEALTH, I WILL TELL MY DOCTOR AT MY NEXT APPOINTMENT. I WILL NOT HOLD MY DENTIST OR ANY OTHER MEMBER OR HIS/HER STAFF, RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM.

REFERRED BY: _____ SIGNATURE: _____

Please review the following list of medications and discuss with your dentist any concerns that you have.

REVIEWED MEDICAL HISTORY BY DENTIST

SIGNATURE: _____