

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 | HIGH OR LOW BLOOD | ANEMIA OR BLOOD DISEASE | MENTAL HEALTH PROBLEMS |
| IRREGULAR HEAT BEAT | PRESSURE | ULCERS | TUBERCULOSIS |
| CONGESTIVE HEART FAILURE | DIABETES | ALLERGIES | HEMOPHILIA |
| HEART MURMUR | LOW SUGAR | KIDNEY TROUBLE | HEADACHES |
| RHEUMATIC FEVER | PERSISTENT COUGH | HEMODIALYSIS | AIDS OR HIV |
| MITRAL VALVE PROLAPSE | THYROID DISEASE | ARTHRITIS | HERPES INFECTION |
| HEART SURGERY | HEPATITIS | ASTHMA | EASY TO BRUISE |
| HEART PACEMAKER | YELLOW JAUNDICE | RHEUMATISM | VASCULAR SURGERY |
| ARTIFICIAL HEART VALVE | LIVER DISEASE | CONTACT LENSES | SINUS TROUBLE |
| CONGENITAL HEART PROBLEMS | VENEREAL DISEASE | ARTIFICIAL JOINTS - PINS OR POST | EYE SURGERY |
| STROKE | CANCER OR TUMORS | STEROIDS (CORTISONE) | CATARACTS |
| EMPHYSEMA | X-RAY OR COBALT TREATMENTS | DRUG ADDICTION | GLAUCOMA |
| LUNG PROBLEMS | CHEMOTHERAPY | EPILEPSY | 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: _____