St. Mary Dental

Name:	Date of Birth	Chart #

HEALTH HISTORY QUESTIONNAIRE

CONFIDENTIAL

1. Have you had any health problems in the past five (5) years?........ Yes No
2. Have you seen a physician or other health care provider in the past two (2) years?........ Yes No
 Physician's Name: ______________________ Phone # or City: ______________________
3. Is there any activity your doctor says you cannot do?........ Yes No
 If yes, what are they? ______________________
4. Have you been hospitalized or had a serious injury in the past five (5) years?........ Yes No
5. Have you ever had a bleeding problem?........ Yes No

Please answer each question, check yes or no. If in doubt, leave blank.

Heart/Blood Vessels
- rheumatic fever.......... Yes No
- rheumatic heart disease.......... Yes No
- heart valve damage.......... Yes No
- heart murmur.......... Yes No
- congenital heart defect.......... Yes No
- artificial heart valve.......... Yes No
- prolapsed heart valve.......... Yes No
- high blood pressure.......... Yes No
- heart attack (Year _____)...... Yes No
- TIA/stroke (Year _____)...... Yes No
- heart surgery (Year _____).... Yes No
- vascular surger (Year _____).. Yes No
- pacemaker.......... Yes No
- coronary heart failure.......... Yes No
- congestive heart failure.......... Yes No
- angina pectoris/chest pain...... Yes No
- irregular/rapid heart beats...... Yes No
- other heart/vessel disorder: __________

Blood
- blood clots or thrombosis...... Yes No
- anemia.......... Yes No
- sickle cell disease/trait.......... Yes No
- hemophilia.......... Yes No
- transfusion (Year _____)...... Yes No
- bruise easity for no reason..... Yes No
- other blood disorder: ______________

Nervous System
- epilepsy.......... Yes No
- seizures.......... Yes No
- multiple sclerosis.......... Yes No
- tragedian neuralgia.......... Yes No
- chronic pain.......... Yes No
- anxiety/depression.......... Yes No
- alzheimer's diseas/dementia.... Yes No
- psychiatric treatment.......... Yes No
- psychological counseling...... Yes No
- persistent dizziness/fainting.... Yes No
- persistent numbness/tingling... Yes No
- other nervous/mental disorder: _______
 ____

Head & Neck
- glaucoma.......... Yes No
- chronic sinusitis.......... Yes No
- injury head/neck/jaw/teeth..... Yes No
- headaches/migranes.......... Yes No
- recurrent neck pain.......... Yes No
- frequent nose bleeds.......... Yes No
- other head/neck disorder ___________

Musculoskeletal/Connective Tissue
- sjögren's syndrome.......... Yes No
- arthritis.......... Yes No
- artificial joint (Year _____).... Yes No
- fibromyalgia/rehumatism...... Yes No
- chronic back pain.......... Yes No
- other muscle/bone disorder: __________

Respiratory
- tuberculosis (TB).......... Yes No
- asthma.......... Yes No
- chronic bronchitis.......... Yes No
- emphysema.......... Yes No
- persistent cough.......... Yes No
- cough up bloody sputum....... Yes No
- shortness of breath.......... Yes No
- other respiratory disorde____________

Urinary Tract
- kidney disease.......... Yes No
- renal dialysis.......... Yes No
- venereal disease.......... Yes No
- sexually transmitted disease... Yes No
- other urinary disorder: ______________

Endocrine
- diabetes.......... Yes No
- thyroid/goiter.......... Yes No
- other endocrine disorder: ___________

Digestive System
- hepatitis.......... Yes No
- cirrhosis of liver.......... Yes No
- liver disease.......... Yes No
- ulcers.......... Yes No
- jaundice.......... Yes No
- frequent heart burn/reflux........ Yes No
- frequent nausea/vomiting......... Yes No
- other digestive disorder: ______________

Cancer History
- cancer.......... Yes No
- if yes, what type: ________________
- leukemia.......... Yes No
- benign tumors/growths.......... Yes No
- type of treatments:
  - surgery.......... Yes No
  - radiation therapy.......... Yes No
  - chemotherapy.......... Yes No
  - hormone therapy.......... Yes No

Allergy History

Are you allergic to or have you had a bad reaction to any of the following?
- dental anesthetics.......... Yes No
- penicillin.......... Yes No
- sulfa drugs.......... Yes No
- aspirin.......... Yes No
- latex products.......... Yes No
- metals (including jewelry).. Yes No
- other antibiotics: _______________
- other allergy: __________________

Family History

Has anyone in your family ever had:
- diabetes.......... Yes No
- heart disease.......... Yes No
- depression or anxiety........ Yes No
- tuberculosis.......... Yes No

any disorder that "runs" in your family?
____

Please continue on the other side ➔

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CONFIDENTIAL

Please answer each question, check yes or no. If in doubt, leave blank.

Miscellaneous

- lupus erythematosus………… Yes No
- organ transplant……………… Yes No
  - if yes, which organ?________________
- suppressed immune system..… Yes No
- persistent fever……………… Yes No
- taken steroids/prednisone..….. Yes No
- tested positive for HIV………. Yes No
- diagnosed with AIDS……….. Yes No
- taken prescription diet pills…. Yes No
  - if yes, please check type
  - ☐ pondimin
  - ☐ redux
  - ☐ phen-fen
  - ☐ other: ________________________

Miscellaneous (Con't)

- used tobacco products……… Yes No
  - if yes, what type? ________________
- how much? ________ How long?______
- still using tobacco?................. Yes No
- would you like to quit?........... Yes No
- drink alcoholic beverages…… Yes No
  - if yes, how much? _________________
- used methamphetamine, amphetamines or "speed"…… Yes No
- used intravenous drugs……... Yes No
- used cocaine or "crack"…….. Yes No
- used any other drugs:________________
- are you a recovering addict?.... Yes No

Women Only

- are you pregnant?....................... Yes No
- are you breast feeding?............. Yes No
- are you in menopause?............. Yes No

Do you have any other conditions that you think we should be made aware of? ☐Yes ☐No if yes, please list:

____

Please circle and list medications your are currently taking, include over the counter medications, herbal and nutritional supplements:

steriods/cortisone	heart	antihistamine	hormones	tranquilizers
nitroglycerin	pain	cyclosporine A	nifedipine	anti depressants
oral contraceptive	aspirin	blood thinners	antibiotics	digitalis
insulin/diabetic drugs	thyroid	blood pressure		

_________________________ _________________________ _________________________

_________________________ _________________________ _________________________

_________________________ _________________________ _________________________

_________________________ _________________________ _________________________

_________________________ _________________________ _________________________

I have completed this health history questionnaire to the best of my ability. I will notify Dr. Basta and/or St. Mary Dental staff if any changes occur in my health and/or medications I am currently taking.

____

Signature of Patient, Parent or Legal Guardian Date

Health Updates (must be review every six (6) months or more often as indicated)

Date	Changes to Health History	Patient Signature

Note: A new Health History Questionnaire should be completed at least every two (2) years; more often if indicated or if all updates have been used.