



Name:	Date of Birth	Cha
-------	---------------	-----

HEALTH HISTORY QUESTIONNAI

CONFIDENTIAL

1. Have you had any health problems in the past five (5) years?..... Yes
2. Have you seen a physician or other health care provider in the past two (2) years?..... Yes  
Physician's Name: \_\_\_\_\_ Phone # or City: \_\_\_\_\_
3. Is there any activity your doctor says you cannot do?..... Yes  
If yes, what are they? \_\_\_\_\_
4. Have you been hospitalized or had a serious injury in the past five (5) years?..... Yes
5. Have you ever had a bleeding problem?..... Yes

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
- cirrhosis of liver..... Yes
- liver disease..... Yes
- ulcers..... Yes
- jaundice..... Yes
- frequent heart burn/reflux..... Yes
- frequent nausea/vomiting..... Yes
- other digestive disorder: \_\_\_\_\_

Cancer History

- cancer..... Yes
- if yes, what type: \_\_\_\_\_
- leukemia..... Yes
- benign tumors/growths..... Yes
- type of treatments:
  - surgery..... Yes
  - radiation therapy..... Yes
  - chemotherapy..... Yes
  - hormone therapy..... Yes

Allergy History

- Are you allergic to or have you had a bad reaction to any of the following?
  - dental anesthetics..... Yes
  - penicillin..... Yes
  - sulfa drugs..... Yes
  - aspirin..... Yes
  - latex products..... Yes
  - metals (including jewelry).. Yes
  - other antibiotics: \_\_\_\_\_
  - other allergy: \_\_\_\_\_

Family History

- Has anyone in your family ever had:
  - diabetes..... Yes
  - heart disease..... Yes
  - depression or anxiety..... Yes
  - tuberculosis..... Yes
  - any disorder that "runs" in your family? \_\_\_\_\_

Please continue on the other si



St. Mary Dental

Name:

Date of Birth

Cha

HEALTH HISTORY QUESTIONNAIRE

CONFIDENTIAL

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

Miscellaneous, Miscellaneous (Con't), Women Only sections with various medical questions and checkboxes.

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:

Medication list grid with categories: steroids/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)

Table with 3 columns: 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.

irt #

**RE**

No  
No  
  
No  
  
No  
No

No  
No  
No  
No  
No  
No  
No

—  
  
No  
—  
No  
No

No  
No  
No  
No

No  
No  
No  
No  
No  
No

—  
—

No  
No  
No  
No

,  
-

ide →

irt #

**RE**

No  
No  
No