

Patient's Name _____

Health Questionnaire

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care.

MEDICAL HISTORY

- Physician's Name _____ City/State _____ Phone _____
- Are you under a physician's care? _____ Since when? _____ Why? _____
- When was your last complete physical exam? _____ Are you in good health? Yes No
- List medications currently taking and dosage (including diet pills and anti depressants) _____
- Are you sensitive or allergic to any drugs? Penicillin Tetracycline Sulfa Drugs Aspirin Codeine Sulfites Other
If Other, what drugs? _____
- Are you sensitive to any metals or latex?..... Yes No
- Do you smoke, chew, use snuff or any other forms of tobacco?.... Yes No
- Do you habitually use controlled substances or alcohol?..... Yes No
- Do you have or have you had any of the following known conditions? (Please any known condition):

| | | |
|---|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Herpes | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Head Injuries |
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Angina Pectoris | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Joint Replacements |
| <input type="checkbox"/> Nervous Disorder | <input type="checkbox"/> Tumors or Growths | <input type="checkbox"/> Allergies or Hives |
| <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Tuberculosis (T.B.) |
| <input type="checkbox"/> Epilepsy Seizures | <input type="checkbox"/> Artificial Prosthesis | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Difficulty in Swallowing | <input type="checkbox"/> Heart Ailments or Attack |
| <input type="checkbox"/> X-Ray or Cobalt Treatment | <input type="checkbox"/> Fainting Spells or Seizures | <input type="checkbox"/> Hepatitis or Jaundice |
| <input type="checkbox"/> Radiation Treatment of Any Kind | <input type="checkbox"/> Chemotherapy (Cancer, Leukemia) | <input type="checkbox"/> HIV (Positive) |
| <input type="checkbox"/> Venereal Disease (Syphilis, Gonorrhea) | <input type="checkbox"/> Acquired Immune Deficiency Syndrome (AIDS) | <input type="checkbox"/> Mitral Valve Prolapse |
- Are you pregnant or suspect you may be?..... Yes No
- Do you use any birth control pills?..... Yes No
- Have you had heart surgery, or wear a pacemaker?... Yes No
- Do you have any disease, condition or problem not listed that you think I should know about?..... Yes No

DENTAL HISTORY

- Purpose of appointment _____
- How long since your last dental treatment? _____ When was the last time your teeth were cleaned? _____
- Previous dentist's name _____ City/State _____ Phone _____
- Have you ever had any problems or complications with previous dental treatment?..... Yes No
If Yes, explain _____
- Have you ever had any unfavorable reaction from local anesthetics?..... Yes No
- Do you clench or grind your teeth?..... Yes No
- Does your jaw click or pop?..... Yes No
- Have you ever experienced any pain or soreness in the muscles of your face or around your ear?..... Yes No
- Do you have frequent headaches, neckaches or shoulder aches?..... Yes No
- Does food get caught between your teeth?..... Yes No
- Are any of your teeth sensitive to hot _____ cold _____ sweets _____ pressure _____ ?
- Do your gums bleed or hurt?..... Yes No
- Have you ever had gum treatment or surgery?..... Yes No
What _____ Where _____ When _____
- Are any of your teeth loose, tipped or shifted?..... Yes No
- Are you happy with the appearance and color of your teeth?..... Yes No
- Is there anything you would change about the appearance of your teeth?..... Yes No
- Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? _____
- Do you have any questions or concerns?..... Yes No

I assume financial responsibility and authorize dental treatment to be rendered by the Dentist and his staff that may include x-rays, nitrous oxide, local anesthetic, topical flouride or other treatment that is considered necessary.

Signature _____ Date _____ Relationship _____