HEALTH QUESTIONNAIRE

Name ______________________________ Birth date ______________

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Circle yes or no, whichever applies, in response to the following questions. Your answers are for our records only and will be considered confidential.

DENTAL

Yes No 1. Are you having any discomfort at this time

Yes No 2. Have you ever had any serious trouble associated with previous dental treatment
If so, explain. ______________________________

3. Does dental treatment make you nervous No _____ Slightly_____ Moderately _____ Extremely _____

4. Date of last dental visit. ______________

Yes No 5. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)
If so, when? ______________________________

6. How often do you brush? ______________
Brushes: Soft ☐ Medium ☐ Hard ☐

7. Do you have or have you ever had any of the following

MOUTH			TEETH		
Bleeding, sore gums	Yes	No	Loose teeth	Yes	No
Unpleasant taste/bad breath	Yes	No	Sensitive to hot	Yes	No
Burning tongue/lips	Yes	No	Sensitive to cold	Yes	No
Frequent blisters, lips/mouth	Yes	No	Sensitive to sweets	Yes	No
Swelling/lumps in mouth	Yes	No	Sensitive to biting	Yes	No
Ortho treatments (braces)	Yes	No	Food impaction	Yes	No
Biting cheeks/lips	Yes	No	Clenching/grinding	Yes	No
Clicking/popping jaw	Yes	No	If so , when?	______________	
Difficulty opening/closing jaw	Yes	No	Shifting in bite	Yes	No
			Change in bite	Yes	No

8. Do you use the following

Brush	Yes	No	Fluoride rinse	Yes	No
Dental Floss	Yes	No	Other	______________	

MEDICAL

Yes No 1. Has there been any change in your general health within the past year

2. My last physical examination was on: ______________________________

Yes No 3. Are you now under the care of a physician
If so, what is the condition being treated ______________________________

4. The name and address of my physician is: ______________________________
____

Yes No 5. Have you had any serious illness, been hospitalized or had an operation within the past five (5) years
If so, what was the problem ______________________________

6. Do you have or have you had any of the following diseases or problems

Yes No a. Rheumatic fever or rheumatic heart disease
Yes No b. Congenital heart disease
Yes No c. Cardiovascular disease (heart trouble, heart attack, heart murmur, coronary insufficiency, coronary occlusion, high/low blood pressure, arteriosclerosis, stroke, etc.)
Yes No 1) Do you have pain in chest upon exertion
Yes No 2) Are you ever short of breath after mild exercise
Yes No 3) Do your ankles swell
Yes No 4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep
Yes No d. Artificial or replacement valves
Yes No e. Pacemaker
Yes No f. Allergies, Asthma or Hay Fever
Yes No g. Sinus trouble
Yes No h. Hives or a skin rash
Yes No I. Fainting spells or seizures
Yes No j. Diabetes
Yes No 1) Do you have to urinate (pass water) more than six times a day
Yes No 2) Are you thirsty much of the time
Yes No 3) Does your mouth frequently become dry