HEALTH QUESTIONAIRE (Confidential)

Patient's Name_____ Male / Female Age_____ Height_____ Weight_____

Patient's Physician_____ Physician's Phone_____ Patient's Dentist_____

_____

Have you had any of the following?

YES	NO		YES	NO		YES	NO	
☐	☐	Recent Illness (within 1 yr)	☐	☐	Heart Attack	☐	☐	Anemia
☐	☐	Cough cold or flu (within 2 mos.)	☐	☐	Irregular heartbeat, Pacemaker	☐	☐	Tumor/cancer treatment
☐	☐	Nasal Obstruction	☐	☐	Heart murmur	☐	☐	Thyroid disease
☐	☐	Loud snoring	☐	☐	Rheumatic fever	☐	☐	Seizures or Epilepsy
☐	☐	Difficulty opening mouth	☐	☐	Mitral Valve Prolapse	☐	☐	Psychiatric Treatment
☐	☐	TMJ problems/clicks/locks	☐	☐	High blood pressure	☐	☐	Liver disease
☐	☐	Lung Disease	☐	☐	High Cholesterol	☐	☐	Cirrhosis
☐	☐	Shortness of breath	☐	☐	Blood vessel grafts	☐	☐	Jaundice
☐	☐	Asthma/inhaler __as needed__daily	☐	☐	Heart surgery	☐	☐	Hepatitis A,B, or C
☐	☐	Bronchitis-how long ago?_____	☐	☐	Stroke	☐	☐	Stomach ulcer/Blood in Stool
☐	☐	Emphysema	☐	☐	Arthritis	☐	☐	Diabetes (IDD M or NIDDM)
☐	☐	Tuberculosis (TB)	☐	☐	Artificial Joints	☐	☐	Kidney Disease/Blood in urine
☐	☐	Heart Failure	☐	☐	Cortisone/ACTH	☐	☐	ARC or HIV+/STD
☐	☐	Chest Pain	☐	☐	Excessive bleeding	☐	☐	Other, please list:
☐	☐	Autoimmune Disorder	☐	☐	Glaucoma			_____

YES	NO	
☐	☐	Are you in good health?
☐	☐	Are you having pain or discomfort at this time?
☐	☐	Have you had a bad experience with previous dental or surgical treatment?
☐	☐	Have you been under the care of a physician or hospitalized during the past two years? If yes, for what?_____
☐	☐	Have you ever gone to sleep for an operation? If yes, for what?_____ Describe any complications_____
☐	☐	Have any immediate family members had a serious reaction to general anesthetic?
☐	☐	Are you taking medications **of any kind**, including blood thinners, aspirin, diet pills or vitamins? If yes, please list: _____ _____
☐	☐	Have you ever used recreational or IV drugs (marijuana, cocaine, etc.) or Phen/Fen? Please list, as they can be dangerous In conjunction with anesthetic drugs:_____
☐	☐	Do you smoke? If yes, how long?_____ How many packs per day?_____
☐	☐	**Women**, are you pregnant? How many months?_____ Nursing?_____ ***Antibiotics and pain medication can stop absorption of birth control pills. Use another method of contraception for the remainder of that menstrual cycle.**
☐	☐	Do you wear dentures/partials?
☐	☐	Do you wear contact lenses?
☐	☐	Have you undergone eye surgery in the past 8 weeks?
☐	☐	Have you ever or are you now receiving Bisphosphonate drug therapy (Zometa, Fosamax, Actonel, Reclast)? How long? _____
☐	☐	Do you have any other information you think we should know about? _____
☐	☐	Within the last 120 days, have you or a family member traveled outside of the U.S.?_____ Where? _____

ARE YOU ALLERGIC TO? (For any "YES" answers, please indicate the type of reaction (i.e. rash, nausea, etc…)

YES	NO		YES	NO	
☐	☐	Penicillin/Ampicillin/Amoxicillin: _____	☐	☐	Aspirin_____
☐	☐	Novacaine-Local anesthetics: _____	☐	☐	Latex:_____
☐	☐	Codeine:_____	☐	☐	Eggs or Egg whites:_____
☐	☐	Sulfa Drugs:_____	☐	☐	Shell Fish or Iodine:_____
			☐	☐	Other:_____

To the best of my knowledge, all the preceding answers are true and correct. If I have any change in my health status or if my medications change I will inform the doctor accordingly.

Patient/Legal Guardian Signature: _____ Date: _____

If minor, relationship to patient: _____

Signature of Dr. Whitworth: _____