HEALTH QUESTIONAIRE

Patient Name ____________________

Sex ________ Age ____ Height ____ Weight ______

Date: __________ Occupation ____________________

Marital Status ______________

Directions

Please circle the appropriate answer to the questions and fill in the blanks where indicated. Answer all questions and blanks completely.

Answers to the following questions are for our records and will be considered confidential.

1. Are you in good health...................................………… Yes No
   A. Has there been any change in your general health ....………… Yes No
2. My last physical examination was on ____________________
3. Are you now under the care of a physician ....………… Yes No
   A. If so, what is the condition being treated ____________________
4. The name and address of my physician is: ____________________ ____________________
5. Have you ever had a serious illness or operation ....………. Yes No
   A. If so, what was the illness or operation: ____________________ ____________________ ____________________
6. Have you been hospitalized with any of the following within the last five (5) years ....…………… Yes No
   A. Do you have a persistent cough or cough up blood ....…………… Yes No
   B. Low blood pressure ....…………… Yes No
   C. Venereal Disease ....…………… Yes No
   D. AIDS or HIV+.......................................…………… Yes No
   E. Other ____________________ ____________________
7. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma ....………….. Yes No
   A. Do you bruise easily ....…………… Yes No
   B Have you ever required a blood transfusion ………… Yes No
   If so, explain the circumstances ____________________ ____________________
8. Do you have any blood disorder such as anemia..…………. Yes No
9. Have you had surgery or x-ray treatment for a tumor, growth or other condition of your mouth or lips..……………. Yes No
10. Are you taking any drug or medication...........…………….. Yes No
    If so, what ____________________ ____________________
11. Are you taking any of the following:
    A. Antibiotics or sulfa drugs........................…………… Yes No
    B. Anticoagulants (blood thinners)................…………… Yes No
    C. Medicine for high blood pressure.............…………….. Yes No
    D. Cortisone (steroids)................................…………… Yes No
    E. Tranquilizers..…………… Yes No
    F. Aspirin...…………… Yes No
    G. Insulin, Tolbutamide (Orinase) or similar drug………. Yes No
    H. Digitalis or drugs for heart trouble........………………. Yes No
    I. Nitroglycerin..……………… Yes No
    J. Fen-Phen (now, or in the past) or any related drugs such as Ionimin, Adipex, Phentermine, Fastin, Pondimin (Fenfluramin), and Redux (dexfenfluramine)……...……… Yes No
    K. Oral Contraceptives................................ ………… … Yes No
    If so, what are you using ____________________ ____________________
    L. Other ____________________ ____________________
12. Do you have a heart murmur/mitral valve prolapse…........… Yes No
13. Do you have any implants and/or Prosthesis (i.e. knee joints, elbow pins, etc.)... Yes No
    If so, explain ____________________
14. Do you drink alcoholic beverages....................................... Yes No
15. Do you smoke...…...... Yes No
    If so, how much ____________________
16. Do you have or have you had any of the following diseases or problems:
    A. Rheumatic fever or rheumatic heart disease................... Yes No
    B. Congenital heart lesions... Yes No
    C. Cardiovascular disease (heart trouble, heart attack, coronary occlusion, high blood pressure, arteriosclerosis, stroke)... Yes No
       1) Do you have pain in the chest upon exertion........ Yes No
       2) Are you ever short of breath after mild exercise... Yes No
       3) Do you get short of breath when you lie down or do you require extra pillows when you sleep.......... Yes No
    D. Allergy.. Yes No
    E. Asthma or hay fever.. Yes No
    F. Hives or skin rash.. Yes No
    G. Fainting spells or seizures... Yes No
    H. Diabetes.. Yes No
       1) Do you have to urinate (pass water) more than six (6) times a day.. Yes No
       2) Are you thirsty much of the time........................ Yes No
       3) Does your mouth frequently become dry............ Yes No
    I. Hepatitis, jaundice, or liver disease.............................. Yes No
    J. Arthritis.. Yes No
    K. Inflammatory rheumatism (painful, swollen joints).. Yes No
    L. Stomach ulcers.. Yes No
    M. Kidney trouble.. Yes No
    N. Tuberculosis... Yes No
17. Are you allergic or have you reacted adversely to:
    A. Local anesthetic... Yes No
    B. Penicillin or other antibiotics...................................... Yes No
    C. Barbiturates, sedatives, or sleeping pills................... Yes No
    D. Sulfa Drugs... Yes No
    E. Aspirin.. Yes No
    F. Iodine.. Yes No
    G. Latex…………………………………………………… Yes No
    H. Other: ____________________
18. Have you had any serious trouble associated with previous dental treatment.. Yes No
    If so, explain ____________________ ____________________
19. Are you pregnant or could you be....................................... Yes No
    If so, when are you due? ____________________

I certify to the best of my knowledge that the above information is correct and that if there are any changes in the above, I agree to notify my dentist before my next visit.

Patient/Guardian ____________________ Date ________

Doctor ____________________ Date ________

Updates:

Patient/Guardian ____________ Doctor's Initials ______ Date ________

Patient/Guardian ____________ Doctor's Initials ______ Date ________

Patient/Guardian ____________ Doctor's Initials ______ Date ________