

HEALTH QUESTIONNAIRE

Today's Date

Patient's Name

Birthdate

____/____/____

Name of person completing this form (if different from patient) and relation to patient: _____

Please answer the following questions to the best of your ability, realizing that true and accurate answers are important to the delivery of quality care. **All information you provide will be kept confidential.**

****PLEASE ANSWER BY CIRCLING Yes (Y) OR No (N) FOR EACH INDIVIDUAL QUESTION.**

1. Are you in good health? Y N
2. Has there been any change in your general health in the past year? Y N
3. Date of last check up by physician: _____
4. Are you currently under a physician's care? Y N
If so, what for? _____
Treating Physician's Name: _____ Phone Number: _____
5. Have you had any serious illness, operations, or hospitalizations? Y N
If so, describe and give approximate dates: _____
6. Have you ever had intravenous sedation or general anesthesia? Y N
Were there any adverse effects? Y N
7. Do you generally tolerate dental treatment well? Y N

DO YOU HAVE OR HAVE YOU EVER HAD:

- A. Heart disease that was detected at birth? Y N
- B. Rheumatic fever or Rheumatic heart disease? Y N
- C. Cardiovascular disease (chest pain, heart trouble, heart attack, coronary artery disease, high blood pressure, stroke, palpitations, heart surgery, angioplasty, pacemaker)? Y N
- D. Lung disease (asthma, emphysema, chronic cough, bronchitis, pneumonia, TB, shortness of breath, severe cough)? Y N
- E. Neurologic Disorders (seizure, epilepsy, fainting, dizziness, nervous disorder)? Y N
- F. Blood Disease (bleeding disorder, anemia, blood transfusion, do you bruise easily)? Y N
- G. Liver Disease (jaundice, hepatitis)? Y N
- H. Kidney Disease? Y N
- I. Diabetes? Y N
- J. Thyroid Disease (hypothyroidism, tumor)? Y N
- K. Arthritis? (which joints) Y N
- L. Stomach ulcers or intestinal problems? Y N
- M. Glaucoma? Y N
- N. Frequent or recurring mouth sores? Y N
- O. Implants/artificial joints anywhere in your body? (heart valve, hip, knee) Y N
- P. Radiation (x-ray treatment for cancer) in head and neck region? Y N
- Q. Noises in jaw joint, pain near ear when chewing, do you grind or clench teeth? Y N
- R. Sinus or nasal problems? Y N
- S. Any disease, drug or transplant operation that has depressed your immune system? Y N
- T. Recurrent infections of any kind? Y N

ARE YOU TAKING OR USING ANY OF THE FOLLOWING:

- A. Antibiotics? Y N
- B. Anticoagulants (blood thinners)? Y N
- C. Thyroid medications? Y N
- D. Antihistamines, decongestants? Y N
- E. High blood pressure or heart medication? Y N
- F. Steroids? Y N
- G. Tranquilizers, Antidepressants? Y N

****Please continue on other side of form****

- H. Stomach or GI medications (antacids, etc.)? Y N
- I. Cholesterol reducing drugs? Y N
- J. Aspirin, ibuprofen, NSAIDS or anti-inflammatory drugs, narcotics or other pain relievers? Y N
- K. Weight reduction pills or diet aids (over the counter or “natural” products)? Y N
- L. Vitamins, natural remedies (ginko biloba, ephedra, ginseng, etc.) or other supplements? Y N
- M. Marijuana, cocaine or other “recreational” drugs? Y N
- N. Any other regular medications, pills, supplements or drugs? Y N
- O. Bisphosphonates for osteoporosis? Which kind? _____ Y N
- P. IV Bisphosphonates – Aredia or Zometa? YN

PLEASE LIST ALL CURRENT MEDICATIONS HERE _____

ARE YOU ALLERGIC TO OR HAD A BAD REACTION FROM:

- A. Local anesthetic (Novocain-like drugs)? Y N
- B. Penicillin, Amoxicillin, Cephalosporins? Y N
- C. Other antibiotics? _____
- D. Barbiturates, sedatives? Y N
- E. Aspirin, ibuprofen, NSAIDS, or other pain medications? Y N
- F. Codeine or other narcotics or opioids? Y N
- G. Latex? Y N
- H. Other allergies or reactions? Y N

Please list: _____

- Do you have hay fever, frequent skin rashes, etc.? Y N
- Do you use alcohol? How much per day? Y N
- Do you smoke? Y N
- What product and how many per day? _____ For how long? _____
- Do you spit tobacco? _____ For how long? _____
- Are you, or have you been, in a drug or alcohol recovery program? Y N
- Do you have any other disease, condition or problem not listed above that you think the doctor should know about? Y N
- Do you wish to talk to the doctor privately about anything? Y N
- Any additional comments? Y N

WOMEN

- A. Are you taking birth control pills? Y N
- B. Are you pregnant, trying to become pregnant or any chance you might be pregnant? Y N
- C. Are you BREAST FEEDING? Y N
- D. Are you taking hormone replacement? Y N

I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL HEALTH HISTORY AND REALIZE THAT INCOMPLETE INFORMATION MAY HAVE AN ADVERSE EFFECT ON MY TREATMENT. TO THE BEST OF MY KNOWLEDGE, THE INFORMATION ABOVE IS COMPLETE AND ACCURATE.

_____ Date

_____ Signature of person completing Health History

Thank you: Do not write below this line.

Medical update: I have reviewed my health history dated ___/___/_____ and confirm that it accurately states past and present conditions.

Exceptions: _____

_____ Date

_____ Signature of person completing Health Update