

HEALTH QUESTIONNAIRE

Patient Name _____ Address _____

Sex _____ Age _____ Height _____ Weight _____

Name of Employer _____ Home Phone # _____ Cell Phone # _____

Work Phone # _____ Occupation _____ E-mail Address _____

Directions: Please circle the appropriate answer to the questions and fill in the blanks where indicated. Please answer all questions completely. Your answers will remain confidential in our records.

1. **Are you in good health?**..... Yes No
2. Have there been any recent changes in your health..... Yes No
What? _____
3. My last physical examination was on _____
4. Are you now under the care of a physician..... Yes No
A. If so, what is the condition being treated _____
5. The name and phone number of my physician is:
Name: _____
Phone # _____
6. Have you had a serious illness or operation..... Yes No
A. If so, what was the illness or operation: _____
Date: _____
7. **Are you taking any of the following:** Yes No
 - A. Antibiotics..... Yes No
 - B. Anticoagulants (blood thinners)..... Yes No
 - C. Antidepressants..... Yes No
 - D. Cortisone (steroids)..... Yes No
 - E. Medicine for high blood pressure..... Yes No
 - F. Tranquilizers..... Yes No
 - G. Aspirin..... Yes No
 - H. Insulin, Tolbutamide (orinase) or similar drug..... Yes No
 - I. Digitalis or drugs for heart trouble..... Yes No
 - J. Nitroglycerin..... Yes No
 - K. Fen-phen (now, or in the past)..... Yes No
If so, has your heart been evaluated..... Yes No
 - L. Oral Contraceptives..... Yes No
 - M. Fosamax or other Bisphosphonate..... Yes No
8. **Are you allergic to or have adversely reacted to:**
 - A. Latex Yes No
 - B. Local anesthetic Yes No
 - C. Penicillin Yes No
 - D. Other antibiotics..... Yes No
 - E. Metals Yes No
 - F. Pain Medication Yes No
 - G. Barbiturates, sedatives, or sleeping pills Yes No
 - H. Other _____
9. Are you taking any other drugs or medication..... Yes No
If so, what _____
10. Women: Are you pregnant or could you be..... Yes No
If so, how many months? _____
Are you nursing..... Yes No

11. **Please indicate any history of the following:**
 - A. Artificial heart valves..... Yes No
 - B. Infective endocarditis..... Yes No
 - C. Valve problems associated with cardiac transplant..... Yes No
 - D. Implants and/or Prosthesis (i.e.. Knee joints, elbow pins, etc.) Yes No
If so, what type, and when was it placed _____
 - E. Congenital heart lesions..... Yes No
 - F. Cardiovascular disease..... Yes No
 - G. History of heart attack..... Yes No
 - H. Coronary Occlusion..... Yes No
 - I. High blood pressure..... Yes No
 - J. History of stroke..... Yes No
 - K. Persistent or bloody cough..... Yes No
 - L. Any bleeding conditions or disorders..... Yes No
 - M. Abnormal bleeding associated with past dental treatment..... Yes No
 - N. Radiation treatment for any condition of the face or mouth..... Yes No
 - O. Asthma..... Yes No
 - P. Tobacco use Yes No
How often _____
 - Q. Illicit drug use..... Yes No
When & what _____
 - R. Fainting spells or seizures..... Yes No
 - S. Diabetes..... Yes No
 - T. AIDS or HIV+..... Yes No
 - U. Sexually Transmitted Diseases..... Yes No
 - V. Hepatitis, or any liver condition..... Yes No
 - W. Kidney Problems..... Yes No
 - X. Arthritis or inflammatory rheumatism..... Yes No
 - Y. Neurological condition..... Yes No
 - Z. Depression..... Yes No
12. Do you have any other medical conditions..... Yes No
If so, please list _____
13. Have you had any serious trouble associated with previous dental treatment..... Yes No
If so, explain _____

Doctor's Notes:

I certify that to the best of my knowledge the above information is correct. I agree to notify my dentist immediately if there are any changes to the above.

Patient/Guardian _____ Date _____

Doctor _____ Date _____