

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. Venereal Disease..... 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 _____