Health Questionnaire

Please Print

Today's Date	Patient's Name	Sex	Birthdate
_____/_____/_____	_____	☐ Male ☐ Female	_____/_____/_____

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

_____ _____

Printed Name *Relation*

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
8. 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, pacemaker, stroke, high blood pressure, palpitations, heart surgery, angioplasty)?	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? If so, 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, transplant operation or HIV that has depressed your immune system?	Y	N
T. Recurrent infections of any kind?	Y	N

PLEASE CONTINUE ON NEXT PAGE

9. 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? ……	Y	N
F. Steroids? ……	Y	N
G. Tranquilizers, Antidepressants? ……	Y	N
H. Stomach or GI medications (antacids, etc) ……	Y	N
I. Cholesterol reducing drugs? ……	Y	N
J. Aspirin, ibuprofen, NSAIDS or anti-inflammatory drugs, narcotics, opioids, 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

PLEASE LIST ALL CURRENT MEDICATIONS HERE: _____

_____

_____

10. Are you ALLERGIC to or had a bad reaction from:

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

11. Do you have hay fever, frequent skin rashes, etc? …… Y N

12. Do you drink alcohol? How much per day? _____ Y N

13. Do you smoke? …… Y N

What product and how many per day? _____ For how long? _____

14. Do you use spit tobacco? …… For how long? _____ Y N

15. Are you, or have you been, in a drug or alcohol recovery program? …… Y N

16. Do you have any other disease, condition or problem not listed that you think the doctor should know about? ... Y N

17. Do you wish to talk to the doctor privately about anything? …… Y N

18. Any additional comments? _____

19. **WOMEN**

A. Are you taking birth control pills? ……	Y	N
B. Are you pregnant, trying to become pregnant or <u>any chance</u> you might be pregnant? ……	Y	N
C. Are you BREAST FEEDING? ……	Y	N
D. Are you taking hormonal 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 Questionnaire Doctor's Initials

THANK YOU. *Please return this form to the receptionist before completing others in this packet; do not write below the line.*

Medical Updates: Reviewed by Dr._____ Date _____	Medical Updates: Reviewed by Dr._____ Date _____	Medical Updates: Reviewed by Dr._____ Date _____	Medical Updates: Reviewed by Dr._____ Date _____	Medical Updates: Reviewed by Dr._____ Date _____