HEALTH QUESTIONNAIRE

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care.

Please answer each question. Circle **Yes** or **No** where applicable. Example: Are you alive .... (**Yes**) No

MEDICAL HISTORY

1. Are you in good health? .... **Yes** **No**
2. Date of last physical examination ______ Name Of Physician ______ Phone ______
3. Are you now under the care of a physician? .... **Yes** **No**
   If so, what is the condition being treated? ______
4. Have you ever had any serious illness or operation? .... **Yes** **No**
   If so, what illness or operation? ______
5. Have your even been hospitalized? .... **Yes** **No**
   If so, what was the problem? ______
6. Are you taking any medicine ☐ Yes ☐ No or any recreational drugs (marijuana, cocaine, etc.)? .... **Yes** **No**
   If so, what? ______ What dosage? ______
7. Have you ever been pre-medicated with antibiotics for your dental treatment? .... **Yes** **No**
8. Are you sensitive or allergic to any drugs? ☐ Penicillin; ☐ Erythromycin ☐ Tetracycline; ☐ Sulfa Drugs; ☐ Aspirin; ☐ Codeine;
   ☐ Other If Other, what drugs? ______
9. Do you have or have you had any of the following:

	YES	NO		YES	NO		YES	NO		YES	NO		YES	NO
Heart Murmur	☐	☐	Excess. Bleeding	☐	☐	Cold Sores	☐	☐	Thyroid Disease	☐	☐	Ulcers	☐	☐
Rheumatic Fever	☐	☐	Stomach Ulcers	☐	☐	Bruise Easily	☐	☐	Kidney Disease	☐	☐	Leukemia	☐	☐
Joint Replacement	☐	☐	Asthma	☐	☐	Sinus Trouble	☐	☐	Liver Disease	☐	☐	Cancer	☐	☐
Artificial Prosthesis	☐	☐	Tuberculosis (T.B)	☐	☐	Difficulty in Swallowing	☐	☐	Respiratory Disease	☐	☐	Tumors or Growths	☐	☐
Glaucoma	☐	☐	Herpes	☐	☐	Pain in Jaw Joint	☐	☐	Sickle Cell Disease	☐	☐	Chemotherapy	☐	☐
Diabetes	☐	☐	Blood Transfusion	☐	☐	Allergies or Hives	☐	☐	Blood Disease	☐	☐	Radiation Treatment	☐	☐
High Blood Pressure	☐	☐	Hepatitis A-B-C	☐	☐	Hay Fever	☐	☐	Mental Disorder	☐	☐	Jaundice	☐	☐
Heart Failure	☐	☐	Drug Addiction	☐	☐	Emphysema	☐	☐	Cerebral Palsy	☐	☐	Allergic to latex	☐	☐
Stroke	☐	☐	Venereal Disease	☐	☐	Arthritis	☐	☐	Epilepsy or Seizure	☐	☐	Other ______	☐	☐
Angina Pectoris	☐	☐	(Syphilis, Gonorrhea)			Rheumatism	☐	☐	Nervous Disorders	☐	☐			
Congenital Heart Lesions	☐	☐	HIV Positive	☐	☐	Tonsilitis	☐	☐	Fainting Spells	☐	☐			
Heart Ailment or Attack	☐	☐	Acquired Immune			Psychiatric Treatment	☐	☐	Anemia	☐	☐			
Mitral Valve Prolapse	☐	☐	Def. Synd (AIDS)	☐	☐	Cortisone Medicine	☐	☐	Head Injuries	☐	☐			

10. Have you taken FEN-PHEN or REDUX ? .... Yes No
11. Do you wear a cardiac pacemaker, or have you had heart surgery .... **Yes** **No**
12. Do you have any disease, condition or problem not listed that you think I should know about? .... **Yes** **No**
    If so, what? ______
13. (Women) Are you pregnant? If so how many months ______ .... **Yes** **No**
14. (Women) Do you have any problems associated with your menstrual period? .... **Yes** **No**
15. (Women) Do you take birth control pills? .... **Yes** **No**

DENTAL HISTORY

1. Have you ever had a local anesthetic (Novocaine, etc.)? .... **Yes** **No**
2. Have you ever had any unfavorable reaction from a local anesthetic? .... **Yes** **No**
3. Have you had any serious trouble associated with any previous dental treatment? .... **Yes** **No**
   If so, explain ______
4. How long since your last full mouth X-Rays? ______
5. How long since your last dental treatment? ______
6. Does dental treatment make you nervous .... **Yes** **No**
   If **Yes**, Check ✓: ☐ Slightly ☐ Moderately ☐ Extremely
7. Would you desire to be pre-sedated? .... **Yes** **No**

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medications change, I will, without fail, inform the doctor at my next appointment.

Date ______ **Signature** ______

Year 2
Changes in Health ______

Date ______ **Signature** ______

Year 3
Changes in Health ______

Date ______ **Signature** ______

Health Questionnaire MUST be updated every year

REVIEWED BY
______ YEAR 1
______ YEAR 2
______ YEAR 3

DO NOT WRITE IN THIS SPACE

	Year 1	Year 2	Year 3
Date			
BP	/	/	/
Pulse			
Temp			
By			