Health Questionnaire

Patient Name

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. Place and (X) in the appropriate ☐ where applicable.

MEDICAL HISTORY

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	Yes	No
1. Are you in good health?	☐	☐
2. Date of last physical examination ______		
3. Are you now under the care of a physician?	☐	☐
If so, what is the condition being treated? ______		
4. Have you ever had any serious illness or operation?	☐	☐
If so, what illness or operation? ______		
5. Have you ever been hospitalized?	☐	☐
If so, what was the problem? ______		
6. Are you taking any medicine?	☐	☐
or any recreational drugs (marijuana, cocaine, etc.)?	☐	☐
if so, what/& what dosage? ______		
7. Do you use Tobacco	☐	☐
8. Have you ever been pre-medicated with antibiotics for your dental treatment?	☐	☐
9. Are you sensitive or allergic to any drugs? ☐ Penicillin ☐ Tetracycline ☐ Sulfa Drugs ☐ Aspirin ☐ Codeine ☐ Other ______		
10. Do you wear a cardiac pacemaker, or have you had heart surgery?	☐	☐
11. Do you have any disease, condition or problem not listed ***(in Question #14)*** that you think I should know about?	☐	☐
If so, what? ______		
12. (Women) Are you pregnant? ☐ ☐ If so, how many months? ______		
13. (Women) Do you take birth control pills?	☐	☐

14. Do you have or have you had any of the following:

	Yes	No		Yes	No		Yes	No
Herpes	☐	☐	Asthma	☐	☐	Cortisone Medicine	☐	☐
Diabetes	☐	☐	Emphysema	☐	☐	Tuberculosis	☐	☐
Cold Sores	☐	☐	Hay Fever	☐	☐	HIV	☐	☐
Heart Murmur	☐	☐	Herpes	☐	☐	(AIDS)	☐	☐
Rheumatic Fever	☐	☐	Tonsilitis	☐	☐	Sickle Cell Disease	☐	☐
Scarlet Fever	☐	☐	Hemophilia	☐	☐	Respiratory Disease	☐	☐
Joint Replacement	☐	☐	Rheumatism	☐	☐	Epilepsy or Seizures	☐	☐
Allergies or Hives	☐	☐	Bruise Easily	☐	☐	Artificial Prosthesis	☐	☐
Excessive Bleeding	☐	☐	Head Injuries	☐	☐	Psychiatric Treatment	☐	☐
High Blood Pressure	☐	☐	Hepatitis/Jaundice	☐	☐	X-ray or Cobalt Treatment	☐	☐
Pain in Jaw Joints	☐	☐	Chicken Pox	☐	☐	Fainting Spells or Seizures	☐	☐
Congenital Heart Lesions	☐	☐	Sinus Trouble	☐	☐	Chemotherapy *(Cancer, Leukemia)*	☐	☐
Difficulty in Breathing	☐	☐	Blood Disease	☐	☐	Radiation Treatment of any kind	☐	☐
Heart Ailments or Attack	☐	☐	Kidney Disease	☐	☐	Liver Disease	☐	☐
Heart Failure	☐	☐	Stomach Ulcers	☐	☐	Venereal Disease	☐	☐
Anemia	☐	☐	Angina Pectoris	☐	☐	Drug Addiction	☐	☐
Strokes	☐	☐	Mental Disorder	☐	☐	Other	☐	☐
Ulcers	☐	☐	Thyroid Disease	☐	☐			
Glaucoma	☐	☐	Cerebral Palsy	☐	☐			
Arthritis	☐	☐	Blood Transfusion	☐	☐			
			Nervous Disorder	☐	☐			
			Tumors or Growths	☐	☐			

DENTAL HISTORY

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	Yes	No
1. Have you ever had an unfavorable reaction from a local anesthetic?	☐	☐
2. Do you have a latex allergy?	☐	☐
3. Are you having pain or discomfort at this time?	☐	☐
4. Reason for this visit ______		
5. How long since your last full-mouth X-Rays? ______		
6. How long since your last dental treatment ______		
What for? ______		
7. Do you feel very nervous about having dental treatment?	☐	☐
If yes (X): ☐ Slightly ☐ Moderately ☐ Extremely		
8. Do your gums bleed easily?	☐	☐
9. Do you have headaches?	☐	☐
If yes, how many per week?		
10. Are you satisfied with the appearance of your teeth?	☐	☐
If no, what would you change? ______		

12. Have you ever:

☐ Worn Dentures ☐ Worn Partial Dentures

☐ Had Orthodontic Care or (Braces)

☐ Had Periodontal Treatment (Gums) ☐ Been treated for TMJ (Jaw Joint)

Consent:
The undersigned herby authorizes Doctor to take X-rays , study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. Refusal of diagnostic aids at any future time will release Doctor of responsibility for early diagnosis. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient) ______ and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand that the use of anesthetic agents embodies a certain risk. This consent shall remain in effect until cancelled.

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Patient ______ **Date** ______ **Witness** ______

Parent or Responsible Party ______ **Relationship to Patient** ______

MEDICAL HISTORY UPDATES

Date ______ **Comments** ______ **Signature** ______

Date ______ **Comments** ______ **Signature** ______

Date ______ **Comments** ______ **Signature** ______