HEALTH QUESTIONAIRE

Patient Name_____
Sex _____Age_____Height_____Weight_____
Date_____ Occupation_____
Marital Status_____

Directions

Please circle the appropriate answer to the questions and fill in the blanks where indicated. Answer all questions and blanks completely, answers to the following are for our records and will be considered confidential.

1. Are you in good health……Yes No
2. Has there been any changes in your general health.Yes No
3. My last physical examination was on_____
4. Are you under the care of a physician……Yes No
   A) If so, what is the condition being treated_____
_____
5. The name and address of my physician is:_____
_____
6. Have you had a serious illness or operation……Yes No
7. Have you been hospitalized or had serious illness within the last (5) years……...Yes No
8. Do you have a persistent cough or cough up blood..Yes No
9. Do you have High/Low blood pressure…… Yes No
10. Do you have a venereal disease……..Yes No
11. Do you have AIDS or HIV+……..Yes No
12. Other_____
_____
13. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma……...Yes No
14. Do you bruise easily……...Yes No
15. Have you ever required a blood transfusion……...Yes No
   A) If so explain the circumstances_____
_____
16. Do you have any blood disorder such as anemia…Yes No
17. Have you had surgery or x-ray treatment for a tumor, growth or other condition of your mouth or lips……..Yes No
18. Are you taking any drug or medication……..Yes No
   A) If so, explain_____
_____
19. Are you taking any of the following?
A. Antibiotics or Sulfa Drugs…… Yes No
B. Anticoagulants (blood thinners)…… Yes No
C. Medicine for high blood pressure…… Yes No
D. Cortisone…….. Yes No
E. Tranquilizers…….. Yes No
F. Aspirin…….. Yes No
G. Insulin, Tolbutamide (Orinase) or similar drug….Yes No
H. Digitalis or drugs for heart trouble…….Yes No
I. Nitroglycerin…….. Yes No
J. Fen Phen (Now, or in the past) or any related drugs such as Ionimin, Adieux, Phentermine, Fastin, Pondimin, (Fenfluramin), and Redux (dexflexfuramine)…….Yes No
K. Oral Contraceptives……Yes No
   A) If so, what are you using_____
L. Other_____
_____
20. Do you have a heart murmur/ mitral valve prolapse ……Yes No
21. Do you Have any implants and / or prosthesis? (i.e. knee joints, elbow pins, etc……..Yes No
22. Do you drink alcoholic beverages……Yes No
23. Do you smoke……Yes No
24. Do you have or have had any of the following diseases or problems:
A) Rheumatic fever or rheumatic heart disease……Yes No
B) Congenital heart lesions……..Yes No
C. Cardiovascular disease (heart trouble, heart attack, coronary occlusion, high blood pressure, arteriosclerosis, or stroke……Yes No
25. Do you have pain in the chest upon exertion…….Yes No
26. Are you ever short of breath after mild exercise...Yes No
27. Do you get short of breath when you lie down or do you Require extra pillows when you sleep……..Yes No
28. Do you have allergies?.....Yes No
   A) If so, explain_____
29. Do you have Asthma or Hay Fever……...Yes No
30. Do you have Hives or skin rash…….Yes No
31. Do you suffer from Fainting spells or Seizures….Yes No
32. Do you have Diabetes……Yes No
33. Do you have to urinate (pass water) more than six (6) times a day……...Yes No
34. Are you thirsty much of the time……..Yes No
35. Does your mouth frequently become dry……..Yes No
36. Do you have or have had Hepatitis, jaundice, or liver disease……..Yes No
37. Do you have Arthritis……Yes No
38. Do you have or have inflammatory rheumatism (painful Swollen joints)…….. Yes No
39. Do you have Stomach Ulcers…… Yes No
40. Do you have Kidney trouble…… Yes No
41. Do you have Tuberculoses…… Yes No
42. Are you allergic or have you reacted adversely to:
   A) Local anesthetic…….. Yes No
   B) Penicillin or other antibiotics…….. Yes No
   C) Barbiturates, sedatives, or sleeping pills……. Yes No
   D) Sulfa Drugs…… Yes No
   E) Aspirin…….. Yes No
   F) Iodine…….Yes No
   G) Latex…….Yes No
43. Have you had any serious trouble associated with Previous treatment?……Yes No
44. Are you Pregnant or could be……Yes No
   If so, when is your due date?_____

I certified to the best of my knowledge that the above information is correct and that if there are any changes in the above, I agree to notify my dentist before my next visit.

Patient / Guardian_____Date_____

Doctor_____Date_____

Updates:

Patient/Guardian_____	Doctor's Initianls_____	Date_____
Patient/Guardian_____	Doctor's Initianls_____	Date_____
Patient/Guardian_____	Doctor's Initianls_____	Date_____