Loving DENTISTRY

HEALTH QUESTIONNAIRE

Accurate completion of this form is necessary in order for us to provide you with appropriate dental care. Your responses are held in strict confidence and will be a part of your confidential private dental record.

Name _____ Date _____

Birthdate_____ Gender: _____Male _____Female

Physician's Name _____ Physician's Phone (_____) _____

Physician's Address _____

Previous Dentist _____Phone (_____) _____ Last Seen _____

Why are you now seeking dental treatment? _____

Please circle your response.

1. Have you ever been told by a physician that you have a **heart murmur?** .....Yes…….No

2. Has your physician ever recommended that you **take antibiotics** before receiving dental treatment?.....Yes…….No

3. Do you now have or have you ever had any **heart trouble** (i.e., Rheumatic Fever, angina, attacks)?.....Yes…….No

4. Do you have **high blood pressure?** .....Yes…….No

4. Do you have any **artificial joints** or **prostheses** (i.e. metal screws, plates, pins, etc.) in your body? .....Yes…….No

6. Have you ever experienced any unusual **reactions or allergies** to any of the following drugs?

A. Penicillin ..... Yes…..No

B. Other antibiotics ..... Yes…..No

C. Codeine ..... Yes…..No

D. Aspirin ..... Yes…..No

E. Sulfa drugs .....Yes…….No

F. Other medicines (please specify below) .....Yes…….No

G. _____

H. _____

Please list all current medications:

	Name of medication	Dosage/mg	Frequency	Condition Treated
1.				
2.				
3.				
4.				
5.				
6.				

7. Do you have any **allergies** (to foods, dust, latex, metal, or other items)?.....Yes…….No

8. Do you use any tobacco products (please circle: cigarettes, cigars, chewing tobacco)? Any past use?.....Yes…….No

9. Have you been examined by a physician within the last year? .....Yes…….No

10. Has there been any change in you general health in the past year? .....Yes…….No

11. Have you lost or gained weight in recent months? .....Yes…….No

12. Have you ever been seriously ill? .....Yes…….No

13. Have you ever been hospitalized? If yes, please explain below ..... Yes…….No

Please continue this form on the reverse side ➔➔➔➔➔➔

14. Have you ever had a blood transfusion? ..... Yes…..No

15. Have you ever been treated for a growth or a tumor in any part of your body? ..... Yes…..No

16. Are you frequently ill? ..... Yes…..No

17. Do you often feel exhausted or fatigued? ..... Yes…..No

18. Have you ever had a painful or swollen joint? ..... Yes…..No

19. Do you bleed for a long time when you cut yourself? ..... Yes…..No

20. Have you ever had any of the following diseases or conditions?

A. Jaundice (yellow skin & eyes) ..... Yes…..No
B. Hepatitis ..... Yes…..No
C. HIV (AIDS) ..... Yes…..No
D. Tuberculosis ..... Yes…..No
E. Venereal disease ..... Yes…..No
F. Heart attack ..... Yes…..No
G. Stroke ..... Yes…..No
H. Ulcers ..... Yes…..No
I. Epilepsy ..... Yes…..No
J. Diabetes ..... Yes…..No
K. Measles ..... Yes…..No
L. Chicken pox ..... Yes…..No
M. Mumps ..... Yes…..No
N. Polio ..... Yes…..No
O. Rheumatic Fever ..... Yes…..No
P. Scarlet Fever ..... Yes…..No
Q. Herpes ..... Yes…..No
R. Glaucoma ..... Yes…..No

21. Do you have any blood disorder such as anemia (thin blood)? ..... Yes…..No

22. Do you have any chest pain on exertion? ..... Yes…..No

23. Are you ever short of breath on mild exertion? ..... Yes…..No

24. Do your ankles ever swell? ..... Yes…..No

25. Do you have a persistent cough? ..... Yes…..No

26. Do you have asthma? ..... Yes…..No

27. Do you ever have hay fever? ..... Yes…..No

28. Do you ever have hives or skin rash? ..... Yes…..No

29. Have you ever experienced an unusual reaction to a dental anesthetic (Novacaine)? ..... Yes…..No

30. Do you usually have to urinate frequently? ..... Yes…..No

31. Are you thirsty much of the time? ..... Yes…..No

32. Has a doctor ever said you had kidney or bladder disease or infection? ..... Yes…..No

33. Has a doctor ever said you had liver disease? ..... Yes…..No

34. Do you have numbness or tingling in any part of your body? ..... Yes…..No

35. Has any part of your body ever been paralyzed? ..... Yes…..No

36. Have you ever had a seizure or convulsion? ..... Yes…..No

37. Do you have a tendency to faint (or have you ever fainted)? ..... Yes…..No

38. Do you frequently have severe headaches? ..... Yes…..No

39. If you are a woman — are you presently pregnant? ..... Yes…..No

This is to certify that the information above is a true representation of my health status as of this date.

Patient Signature _____ **Date** _____

Thank you for taking the time to fill out our health questionnaire so that we can provide you with appropriate dental care.