Last Name: ________________________________ First Name: _____________________________________

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. Check the appropriate box and/or circle box and/or 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 ____
3. Are you under the care of a physician? ………………………………………………………………………………………..…...Yes No
   If so, what condition is being treated? ____
4. Have you ever had any serious illness or operation? …………………………………………………………………….……………....Yes No
   If so, what illness or operation? ____
5. Have you ever been hospitalized? ……………………………………………………………………………………………….…Yes No
   If so, what was the problem? ____
6. Are you taking any medication? ………………………….…………………………………………………………………...…..…...Yes No
   If so, list with dosage ________________________________ ____
7. Are you using any recreational drugs (marijuana, cocaine, etc?) Yes No If so, what ____
8. Have you ever been pre-medicated with antibiotics for dental treatment? ………………………………………………………….…...Yes No
9. Are you sensitive or allergic to any drugs or materials? Yes No If so, please circle.
   Penicillin Tetracycline Sulfa Drugs Aspirin Codeine Latex If other, what drugs? ____

10. Do you have or have you had any of the following: (*Please circle **Y** for Yes or **N** for No – answer all conditions*)

Y/ N Anemia	**Y/N** Hemophilia	**Y/N** Heart Murmur
Y/N Herpes	**Y/N** Cold Sores	**Y/N** Liver Disease
Y/N Stroke	**Y/N** Emphysema	**Y/N** Blood Disease
Y/N Ulcers	**Y/N** Chicken Pox	**Y\N** Drug Addiction
Y/N Diabetes	**Y/N** Bruise Easily	**Y\N** Kidney Disease
Y/N Glaucoma	**Y/N** Head Injuries	**Y\N** Stomach Ulcers
Y/N Arthritis	**Y/N** Heart Failure	**Y\N** Angina Pectoris
Y/N Hay Fever	**Y/N** Scarlet Fever	**Y\N** Mental Disorder
Y/N Tonsillitis	**Y/N** Rheumatism	**Y\N** Cerebral Palsy
Y/N Asthma	**Y/N** Sinus Trouble	**Y\N** Thyroid Diseases
Y/N Back Problems	**Y/N** Artificial Heart Valves	**Y/N** Circulatory Problems

Y\N Tuberculosis	**Y\N** Cortisone Medicine	**Y\N** Heart Ailments or Attack
Y\N Blood Transfusion	**Y\N** Allergies to Metals	**Y\N** Mitro-Valve Prolapse
Y/N Joint Replacement	**Y\N** Excessive Bleeding	**Y\N** X-Ray or Cobalt Treatment
Y/N Nervous Disorder	**Y\N** High Blood Pressure	**Y\N** Fainting Spells or Seizures
Y\N Tumors or Growths	**Y\N** HIV Related Complex	**Y\N** Chemotherapy (Cancer, Leukemia)
Y\N Allergies or Hives	**Y\N** Respiratory Disease	**Y\N** Radiation Treatment of any kind
Y\N Pain in Jaw Joints	**Y\N** Epilepsy or Seizures	**Y\N** Venereal Disease (Syphilis, Gonorrhea)
Y\N Rheumatic Fever	**Y\N** Psychiatric Treatment	**Y\N** Acquired Immune Deficiency Syndrome (AIDS)
Y\N Artificial Prosthesis	**Y\N** Hepatitis or Jaundice	**Y\N** TMJ (Temporomandibular Joint) Disorder
Y\N Sickle Cell Disease	**Y\N** Difficulty in Swallowing	**Y\N** Others: _______________
Y/N Cough up blood	**Y/N** Persistent cough	**Y/N** Pacemaker

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 we should know about? …………………………………….……... Yes No
    If so, please explain ____
13. Do you smoke? Yes No If so, what and how much? Cigarettes Cigars Pipe Tobacco Amount Per Day ______________________________
14. Have you ever taken the drug "Phen-Phen" or "Redux"? ………………………...……………………………………...…...……………... Yes No
15. (Women) Are you pregnant? If so, how many months? _______________ …………………………….…………………………………….. Yes No
16. (Women) Do you take birth control pills? ……………………………………………………………………………………………..……… Yes No

DENTAL HISTORY

1. Have you ever had local anesthetic (Novocain) Nitrous Oxide General Anesthetic…………………………………………………………. Yes No
2. Have you ever had any unfavorable reaction from a local anesthetic, nitrous oxide or general 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? Weeks ________________ Months _________________ Years ________________________
5. How long since your last dental treatment? Weeks ________________ Months _________________ Years ________________________
6. When was your last dental cleaning? Weeks ________________ Months _________________ Years ________________________
7. Does dental treatment make you nervous? Slightly Moderately Extremely ……………………………………………………………… Yes No
8. Would you desire to be pre-sedated? ……………………………………………………………………………………………….. Yes No
9. How long do you want to keep your teeth?____
10. Do you have an existing Partial? ______ Denture? ________ Crown ________Bridge ________ if so date of initial placement ___________________
11. Do you have pain in your jaw or near your ears? ....Yes No
12. Do you experience severe or frequent headaches? ……………………………………………………………………………………Yes No
13. Do you have any inflamed areas in you or around your mouth? ………………………………………………………………………… Yes No
14. Have you had any current or previous injury to your mouth? .... Yes No
15. Have you experienced any growths or sore spots in your mouth? …………………………………………………………………………….. Yes No
16. Does any part of your mouth hurt when clenching? ……………………………………………………………………………………. Yes No
17. Do your gums bleed? ……Yes No
18. Do you have any bad tastes or odors in your mouth? ………………………………………………………………………………………...Yes No
19. Have you ever had instructions on the care of your gums? ....Yes No
20. Have you ever been told that you have gum problems? …………………………………………………………………………………Yes No
21. Have you ever had treatment for gum problems? ……………………………………………………………………………………. Yes No
22. Have you ever had braces? When? ________________ For how long? __________________________ ……………………………………Yes No
23. Do you clench or grind your teeth? ……………………………………………………………………………………………………Yes No
24. Do you chew on only one side of your mouth? Which side? _______________ Why? ____

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____Review By: __________________________________

CONSENT FOR TREATMENT: I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and, to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.
All Services are rendered and accepted under the terms and conditions printed on the reverse hereof:
Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

Signature: ____ Date: _____________________ Relationship to Patient: _____________________