

## 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 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 you ever been hospitalized? .....Yes No  
If so, what was the problem? .....
6. Are you taking any medication? .....Yes No  
If so, what? ..... What 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?  Penicillin  Tetracycline  Sulfa Drugs  Aspirin  Codeine  Latex  Other .....Yes No  
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 Tuberculosis (T.B.)	Y/N Cortisone Medicine	Y/N Heart Ailments or Attack
Y/N Herpes	Y/N Cold Sores	Y/N Liver Disease	Y/N Blood Transfusion	Y/N Allergies to Metals	Y/N Mitro-Valve Prolapse
Y/N Stroke	Y/N Emphysema	Y/N Blood Disease	Y/N Joint Replacement	Y/N Excessive Bleeding	Y/N X-Ray or Cobalt Treatment
Y/N Ulcers	Y/N Chicken Pox	Y/N Drug Addiction	Y/N Nervous Disorder	Y/N High Blood Pressure	Y/N Fainting Spells or Seizures
Y/N Diabetes	Y/N Bruise Easily	Y/N Kidney Disease	Y/N Tumors or Growths	Y/N HIV Related Complex	Y/N Chemotherapy (Cancer, Leukemia)
Y/N Glaucoma	Y/N Head Injuries	Y/N Stomach Ulcers	Y/N Allergies or Hives	Y/N Respiratory Disease	Y/N Radiation Treatment of any kind
Y/N Arthritis	Y/N Heart Failure	Y/N Angina Pectoris	Y/N Pain in Jaw Joints	Y/N Epilepsy or Seizures	Y/N Venereal Disease (Syphilis, Gonorrhea)
Y/N Hay Fever	Y/N Scarlet Fever	Y/N Mental Disorder	Y/N Rheumatic Fever	Y/N Psychiatric Treatment	Y/N Acquired Immune Deficiency Syndrome (AIDS)
Y/N Tonsillitis	Y/N Rheumatism	Y/N Cerebral Palsy	Y/N Artificial Prosthesis	Y/N Hepatitis or Jaundice	Y/N TMJ (Temporomandibular Joint) Disorder
Y/N Asthma	Y/N Sinus Trouble	Y/N Thyroid Diseases	Y/N Sickle Cell Disease	Y/N Difficulty in Swallowing	Y/N Others: .....
Y/N Back Problems	Y/N Artificial Heart Valves	Y/N Circulatory Problems	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, what? .....
13. Do you smoke? If yes, how much?  Cigarettes  Cigars  Packs per day ..... Yes No
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. Do you have an existing Partial? \_\_\_\_\_ Denture? \_\_\_\_\_ Crown \_\_\_\_\_ Bridge \_\_\_\_\_ if so date of initial placement .....
10. Do you have pain in your jaw or near your ears? ..... Yes No
11. Do you experience severe or frequent headaches? ..... Yes No
12. Do you have any inflamed areas in you or around your mouth? ..... Yes No
13. Have you had any current or previous injury to your mouth? ..... Yes No
14. Have you experienced any growths or sore spots in your mouth? ..... Yes No
15. Does any part of your mouth hurt when clenching? ..... Yes No
16. Do your gums bleed? ..... Yes No
17. Do you have any bad tastes or odors in your mouth? ..... Yes No
18. Have you ever had treatment for gum problems? ..... Yes No
19. Do you clench or grind your teeth? ..... Yes No
20. 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: \_\_\_\_\_