

# HEALTH QUESTIONNAIRE

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 questions are for our records and will be considered confidential.**

1. Are you in good health ..... Yes No
  - A. Has there been any change in your general health ..... Yes No
2. My last physical examination was on \_\_\_\_\_
3. Are you now under the care of a physician..... Yes No
  - A. If so, what is the condition being treated \_\_\_\_\_
4. The name and address of my physician is \_\_\_\_\_  
\_\_\_\_\_
5. Have you had a serious illness or operation..... Yes No
  - A. If so, what was the illness or operation \_\_\_\_\_  
\_\_\_\_\_
6. Have you been hospitalized or had serious illness within the last five (5) years..... Yes No
  - A. Do you have a persistent cough or cough up blood..... Yes No
  - B. Low blood pressure ..... Yes No
  - C. Venereal Disease..... Yes No
  - D. AIDS or HIV+ ..... Yes No
  - E. Other \_\_\_\_\_
7. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma..... Yes No
  - A. Do you bruise easily..... Yes No
  - B. Have you ever required a blood transfusion ..... Yes No
  - If so, explain the circumstances \_\_\_\_\_
8. Do you have any blood disorder such as anemia..... Yes No
9. Have you had surgery or x-ray treatment for a tumor, growth or other condition of your mouth or lips..... Yes No
10. Are you taking any drug or medication ..... Yes No
  - If so, what \_\_\_\_\_
11. 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 (steroids) ..... 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, Adipex, Phentermine, Fastin, Pondimin (Fenfluramin), and Redux (dexfenfluramine)..... Yes No
  - K. Oral Contraceptives..... Yes No
  - If so, what (are you using \_\_\_\_\_  
\_\_\_\_\_
  - L. Other \_\_\_\_\_  
\_\_\_\_\_

12. Do you have a heart murmur/mitral valve prolapse..... Yes No
13. Do you have any implants and/or Prosthesis (i.e. knee joints, elbow pins, etc.)..... Yes No
  - If so, explain \_\_\_\_\_
14. Do you drink alcoholic beverages..... Yes No
15. Do you smoke..... Yes No
  - If so, how much \_\_\_\_\_
16. Do you have or have you 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, stroke)..... Yes No
    - 1) Do you have pain in the chest upon exertion..... Yes No
    - 2) Are you ever short of breath after mild exercise ..... Yes No
    - 3) Do you get short of breath when you lie down or do you require extra pillows when you sleep..... Yes No
  - D. Allergy..... Yes No
  - E. Asthma or hay fever..... Yes No
  - F. Hives or skin rash..... Yes No
  - G. Fainting spells or seizures..... Yes No
  - H. Diabetes..... Yes No
    - 1) Do you have to urinate (pass water) more than six (6) times a day..... Yes No
    - 2) Are you thirsty much of the time ..... Yes No
    - 3) Does your mouth frequently become dry..... Yes No
  - I. Hepatitis, jaundice, or liver disease..... Yes No
  - J. Arthritis..... Yes No
  - K. Inflammatory rheumatism (painful, swollen joints) ..... Yes No
  - L. Stomach ulcers..... Yes No
  - M. Kidney trouble..... Yes No
  - N. Tuberculosis ..... Yes No
17. 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
  - H. Other: \_\_\_\_\_
18. Have you had any serious trouble associated with previous dental treatment..... Yes No
  - If so, explain \_\_\_\_\_
19. Are you pregnant or could you be..... Yes No
  - If so, when are you due? \_\_\_\_\_

I certify 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 Initials _____	Date _____
Patient/Guardian _____	Doctor's Initials _____	Date _____
Patient/Guardian _____	Doctor's Initials _____	Date _____