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 check **Yes** or **No** where applicable. Example:
Are you alive? Yes □ No□

Medical History

Are you in good health?	Yes □	No □
Date of last physical examination		
Are you now under the care of a physician?	Yes □	No □
If so, what is the condition being treated?		
Have you ever had a serious illness or operation?	Yes □	No □
If so, what illness or operation?		
Have you ever been hospitalized?	Yes □	No □
If so, what was the problem?		
Are you taking any medication?	Yes □	No □
If so, what? What dosage?		
Are you using any recreational drugs (marijuana, cocaine, etc.)?	Yes □	No □
Have you ever been premedicated with antibiotics for your dental treatment?	Yes □	No □
Are you sensitive or allergic to any drugs or materials?	Yes □	No □
□ Penicillin □ Tetracycline □ Sulfa Drugs □ Aspirin □ Codeine □ Latex □ Other		
If other, what drugs?		

Do you have or have you had any of the following: (Please check **Y** for Yes or **N** for No-answer all conditions):

Y	N		Y	N		Y	N	
□	□	Anemia	□	□	Heart Murmur	□	□	Cortisone Medicine
□	□	Herpes	□	□	Liver Disease	□	□	Allergies to Metals
□	□	Stroke	□	□	Blood Disease	□	□	Excessive Bleeding
□	□	Ulcers	□	□	Drug Addiction	□	□	High Blood Pressure
□	□	Diabetes	□	□	Kidney Disease	□	□	HIV Related Complex
□	□	Glaucoma	□	□	Stomach Ulcers	□	□	Respiratory Disease
□	□	Arthritis	□	□	Angina Pectoris	□	□	Epilepsy or Seizures
□	□	Hay Fever	□	□	Mental Disorder	□	□	Psychiatric Treatment
□	□	Tonsillitis	□	□	Cerebral Palsy	□	□	Hepatitis or Jaundice
□	□	Asthma	□	□	Thyroid Disease	□	□	Difficulty in Swallowing
□	□	Hemophilia	□	□	Tuberculosis (TB)	□	□	Heart Ailments or Attack
□	□	Cold Sores	□	□	Rheumatic Fever	□	□	Congenital Heart Lesions
□	□	Emphysema	□	□	Blood Transfusion	□	□	X-Ray or Cobalt Treatment
□	□	Rheumatism	□	□	Joint Replacement	□	□	Fainting Spells or Seizures
□	□	Chicken Pox	□	□	Nervous Disorders	□	□	Chemotherapy (Cancer, Leukemia)
□	□	Bruise Easily	□	□	Tumors or Growth	□	□	Radiation Treatment of any kind
□	□	Head Injuries	□	□	Allergies or Hives	□	□	Venereal Disease (Syphilis, Gonorrhea)
□	□	Heart Failure	□	□	Pain in Jaw Joints	□	□	Acquire Immune Deficiency Syndrome
□	□	Scarlet Fever	□	□	Artificial Prosthesis	□	□	TMJ (Temporomandibular Joint) Disorder
□	□	Sinus Trouble	□	□	Sickle Cell Disease	□	□	Other:_____

Medical History (Continued)	Yes	No
Do you wear a cardiac pacemaker, or have you had heart surgery?	☐	☐
Do you have any disease, condition, or problem not listed that you think we should know about?	☐	☐
If so, what?		
Do you smoke? If so, how much? (packs per day) ☐ Cigarettes ☐Cigars	☐	☐
(Women) Are you pregnant? If so, how many months?	☐	☐
(Women) Do you have any problems associated with your menstrual period?	☐	☐
(Women) Do you take birth control medication?	☐	☐

Dental History

Have you ever had local anesthetic (Novocain, etc.)?	☐	☐
Have you ever had any unfavorable reaction from a local anesthetic?	☐	☐
Have you had any serious trouble associated with any previous dental treatment?	☐	☐
If so, please explain.		
How long since your full mouth X-Rays? _____ Weeks _____ Months _____ Years		
How long since your last dental treatment? _____ Weeks _____Months _____Years		
Does dental treatment make you nervous? ☐Slightly ☐Moderately ☐Extremely	☐	☐
Would you desire to be pre-sedated?	☐	☐

To the best of my knowledge, all the preceding answers are true and correct. If I ever have any changes in my health or if my medications change, I will, without fail, inform the doctor at my next appointment.

A Date: _____ Signature_____

Update- Since your last visit:

Have you seen a medical doctor? Yes ☐ No ☐
Have you had a change in your medication? Yes ☐ No ☐
Have you had a change in your medical condition or had surgery? Yes ☐ No ☐
Please note changes in health since last visit, if no changes, please write "None".

B Date:_____ Signature:_____

Update- Since your last visit:

Have you seen a medical doctor? Yes ☐ No ☐
Have you had a change in your medication? Yes ☐ No ☐
Have you had a change in your medical condition or had surgery? Yes ☐ No ☐
Please note changes in health since last visit, if no changes, please write "None".

C Date:_____ Signature:_____

DO NOT WRITE IN THIS SPACE

	A	**B**	**C**
Date	_____	_____	_____
B.P.	__/___	___/___	__/__
Pulse	_____	_____	_____
Temp	_____	_____	_____
By	_____	_____	_____

Health Questionnaire must be continually updated!