HEALTH QUESTIONNAIRE

Patient Name: _____
First Name

_____
Last Name

Name of ***Physician:*** _____ Physician's Telephone(_____) _____-_____

Address of Physician: _____
Street City Zip Code

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 on *both sides* of the form. Circle **Yes** or **No** where applicable.

1. Are you in good health? **Yes** **No**
2. Date of last physical examination? _____
3. Are you now under the care of a physician? **Yes** **No**
   If so, what is the condition that 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, what? _____
   Are you taking *BISPHOSPHONATES* (Fosamax, Boniva, Actonel, Reclast, etc.)? **Yes** **No**
7. Are you taking any recreational drugs? **Yes** **No**
   If so, what? _____
8. Have you ever been pre-medicated with antibiotics for your dental treatment? **Yes** **No**
9. Are you sensitive or allergic to any drugs or materials? **Yes** **No**

   ☐Penicillin ☐Tetracycline ☐Sulfa Drugs ☐Aspirin ☐Codeine ☐Latex ☐Metal ☐Other

   If Other, what drugs? _____
10. Do you have or have you had any of the following? (Please check ✔all that apply)

☐Acquired Immune Deficiency Syndrome
☐Anemia
☐Angina Pectoris
☐Arthritis
☐Asthma
☐Blood Disease
☐Bruise Easily
☐Chemotherapy (Cancer, Leukemia)
☐Chicken Pox
☐Cold Sores
☐Congenital Heart Lesions
☐Diabetes
☐Drug Addiction
☐Epilepsy or Seizures
☐Excessive Bleeding
☐Fainting Spells
☐Glaucoma
☐Hay Fever
☐Head Injuries
☐Heart Ailments or Attack
☐Heart Failure
☐Heart Murmur
☐Hemophilia
☐Hepatitis or Jaundice
☐Herpes
☐High Blood Pressure
☐HIV Related Complex
☐Implant _____
☐Kidney Disease
☐Liver Disease
☐Nervous/Emotional Problems
☐Osteoporosis
☐Psychiatric Treatment
☐Radiation Treatment of any kind
☐Respiratory Disease
☐Rheumatism
☐Scarlet Fever
☐Seizures
☐Sinus Trouble
☐Sleep Apnea
☐Snoring
☐Stomach Ulcers
☐Stroke
☐Tonsillitis
☐Ulcer
☐Venereal Disease (Syphilis, Gonorrhea)
☐X-Ray or Cobalt Treatment

11. Do you wear a cardiac pacemaker, or have you had heart surgery? **Yes** **No**
12. Do you have any disease, condition, or problem 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
14. Have you ever taken the drugs "Phen-Phen" or "Redux"? **Yes** **No**
15. (Women) Are you pregnant? If so, how many months? **Yes** **No**
16. (Women) Do you have any problems associated with your menstrual period? **Yes** **No**
17. (Women) Do you take any birth control medication? **Yes** **No**

HEALTH HISTORY

To the best of my knowledge, all of the preceding answers regarding my health history 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. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient/Guardian Signature _____ *Date* _____

Relationship to Patient (if patient is a minor) _____

Reviewed by _____ Date _____