HEALTH QUESTIONNAIRE

Name ______________________________ Birth date ______________

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Circle yes or no, whichever applies, in response to the following questions. Your answers are for our records only and will be considered confidential.

DENTAL

1. Are you having any discomfort at this time .... Yes No
2. Have you ever had any serious trouble associated with previous dental treatment? .... Yes No
   If so explain? ______________
3. Does dental treatment make you nervous? No ______ Slightly ______ Moderately ______ Extremely ______
4. Date of last dental visit ______________
5. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? .... Yes No
   If so when? ______________
6. How often do you brush ______________
   Brush is: Soft ☐ Medium ☐ Hard ☐
7. Do you have or have you ever had any of the following?

MOUTH			TEETH		
Bleeding, sore gums	Yes	No	Loose teeth	Yes	No
Unpleasant taste/bad breath	Yes	No	Sensitive to hot	Yes	No
Burning tongue/lips	Yes	No	Sensitive to cold	Yes	No
Frequent blisters, lip/mouth	Yes	No	Sensitive to sweets	Yes	No
Swelling/lumps in mouth	Yes	No	Sensitive to biting	Yes	No
Ortho treatments (braces)	Yes	No	Food impaction	Yes	No
Biting cheeks/lips	Yes	No	Clenching/grinding	Yes	No
Clicking/popping jaw	Yes	No	If so, when ______		
Difficulty opening or closing jaw	Yes	No	Shifting in bite	Yes	No
			Change in bite	Yes	No

8. Do you use the following?
   Brush .... Yes No
   Dental floss .... Yes No
   Fluoride rinse .... Yes No
   Other ______________

MEDICAL

1. Has there been any change in your general health within the past year .... Yes No
2. My last physical examination was on ______________
3. Are you now under the care of a physician .... Yes No
   If so, what is the condition being treated ______________
4. The name and address of my physician is ______________
   ____
5. Have you had any serious illness within the past five (5) years .... Yes No
   If so, what was the illness ______________
6. Have you been hospitalized or had an operation within the past five (5) years .... Yes No
   If so, what was the problem ______________
7. 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 disease .... Yes No
   c. Cardiovascular disease (heart trouble, heart attack, heart murmur, coronary insufficiency, coronary occlusion, high/low blood pressure, arteriosclerosis, stroke, etc.) .... Yes No
      1) Do you have pain in chest upon exertion .... Yes No
      2) Are you ever short of breath after mild exercise .... Yes No
      3) Do your ankles swell .... Yes No
      4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep .... Yes No
   d. Artificial or replacement valves .... Yes No
   e. Pacemaker .... Yes No
   f. Allergy .... Yes No
   g. Sinus trouble .... Yes No
   h. Asthma or hay fever .... Yes No
   i. Hives or a skin rash .... Yes No
   j. Fainting spells or seizures .... Yes No
   k. Diabetes .... Yes No
      1) Do you have to urinate (pass water) more than six times a day .... Yes No
      2) Are you thirsty much of the time .... Yes No
      3) Does your mouth frequently become dry .... Yes No

l. Hepatitis, jaundice or liver disease .... Yes No
m. Arthritis or inflammatory rheumatism .... Yes No
n. Artificial or replacement joints, prosthetic .... Yes No
o. Digestive system—Ulcers or stomach disorders (colitis) .... Yes No
p. Kidney trouble .... Yes No
q. Tuberculosis .... Yes No
r. Persistent cough or cough up blood .... Yes No
s. Immune System disorders (including AIDS, HIV, ARC) .... Yes No
t. Venereal disease .... Yes No
u. Other ________

8. 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 & when ________
9. Have you ever tested positive for the AIDS virus? .... Yes No
10. Do you have any blood disorder such as anemia? .... Yes No
11. Have you had surgery or x-ray treatment for a tumor, growth, or other condition? .... Yes No
12. 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. Antihistamines .... Yes No
   g. Aspirin .... Yes No
   h. Insulin, tolbutamide (Orinase) or similar drug for diabetes .... Yes No
   i. Digitalis or drugs for heart trouble .... Yes No
   j. Nitroglycerin .... Yes No
   k. Other medications .... Yes No
   l. If "Yes" to any of the above, state drug name, dosage and frequency ________
13. Are you allergic or have you reacted adversely to:
   a. Local anesthetics .... Yes No
   b. Penicillin or other antibiotics .... Yes No
   c. Sulfa drugs .... Yes No
   d. Barbiturates, sedatives, or sleeping pills .... Yes No
   e. Aspirin .... Yes No
   f. Iodine .... Yes No
   g. Codeine or other narcotics .... Yes No
   h. Other ________
14. Do you use any tobacco products .... Yes No
   If so, how much per day and what ________
15. Do you use any alcohol products .... Yes No
   If so, how much per day/week/month and what ________
16. Do you use any caffeinated products (coffee, tea, chocolate, etc.) .... Yes No
   If so, how much per day and what ________
17. Do you have any disease, condition, or problem not listed above that you think I should know about? .... Yes No
   If so, explain ________
18. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation .... Yes No
19. Are you wearing contact lenses .... Yes No
20. Are you experiencing stress or pressure in your work or at home .... Yes No

WOMEN

20. Are you pregnant .... Yes No
21. Do you have PMS or problems associated with your menstrual period .... Yes No
22. Are you taking birth control or hormone therapy .... Yes No

Remarks:

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 change in my medication, I will inform the dentist at the next appointment.

________ ________

Signature of Patient Date Signature of Dentist Date