HEALTH QUESTIONNAIRE

PATIENT NAME_____

INSTRUCTIONS

Answer all questions and fill in blank space when indicated. Answers to the following questions are for our records only and will be confidential.

	YES	NO
1. Have you had food or drink today……		
2. Are you in good health……..		
A) Has there been any change in your general health within the past year……..		
3. My last physical was on_____		
4. Are you under the care of a physician……..		
A) If so, what is the condition being treated_____		
5. The name and address of my physician is: _____		
6. Have you had any serious illness or operation……		
7. Have you been hospitalized or had a serious illness within the past five years…		
8. Do you drink alcoholic beverages……		
9. Do you have or have you had any of the following diseases or problems……..		
A) If so, why_____		
B) Congenital heart lesions or murmurs……..		
C) Cardiovascular disease (heart trouble, heart attack coronary insufficiency, Coronary occlusion, high blood pressure, arteriosclerosis, stroke)……		
1. Do you have pain in the chest upon exertion……		
2. Are you ever short of breath after mild exercise……		
3. Do your ankles swell ……..		
4. Do you get short of breath when you lie down, or do you require extra Pillows when you sleep……..		
D) Allergy……		
E) Asthma or hay fever……..		
F) Hives or hay fever……		
G) Fainting spells or seizures……		
H) Diabetes……..		
1. Do you have to urinate (pass water) more than 6 times a day……		
2. Are you thirsty much of the time……		
3. Does your mouth frequently become dry……		
I) Hepatitis, jaundice or liver disease……..		
J) Arthritis……		
K) Inflammatory rheumatism (painful, swollen joints……..		
L) Stomach ulcers……		
M) Kidney trouble……..		
N) Tuberculosis……		
O) Do you have a persistent cough or cough up blood……		
P) Low blood pressure……		
Q) Venereal disease……		
R) Do you suffer from any type of nervous condition……..		
If so, explain the circumstances_____		
10. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma……		
A) Do you bruise easily……...		
B) Have you ever required a blood transfusion……		
If so, explain the circumstances_____		
11. Have you been infected with the AIDS virus……		
12. Do you have any blood disorders such as anemia……		
13. Have you had surgery or x-ray treatment for a tumor, growth, or Other conditions of you mouth or lip……		

14. Are you taking any drug or medicine…… ____ ____
    If so, what_____
15. Are you taking any of the following?
    A) Antibiotics or sulfa drugs…… ____ ____
    B) Anticoagulants (blood thinner)…….. ____ ____
    C) Medicine for high blood pressure…….. ____ ____
    D) Cortisone (steroids)…… ____ ____
    E) Tranquillizers…… ____ ____
    F) Aspirin…… ____ ____
    G) Insulin, tolbutamide (orinase) or similar drug…… ____ ____
    H) Digitalis or drugs for heart trouble…….. ____ ____
    I) Nitroglycerin…… ____ ____
    J) Amphetamines (speed)…… ____ ____
    K) Cocaine…….. ____ ____
    L) Heroin…… ____ ____
    M) Barbiturates, sedatives or sleeping pills…… ____ ____
    N) Methadone…… ____ ____
    O) Other…….. ____ ____
16. Are you allergic or have you reacted adversely to:
    A) Local anesthetics…… ____ ____
    B) Penicillin or other antibiotics…… ____ ____
    C) Sulfa drugs…… ____ ____
    D) Barbiturates, sedatives or sleeping pills…… ____ ____
    E) Aspirin…… ____ ____
    F) Iodine…… ____ ____
    G) Other…….. ____ ____
17. Have you had any serious trouble associated with any previous dental treatment. ____ ____
    If so, explain_____
18. Do you have any disease, conditions or problem not listed above that you think I should know about…….. ____ ____
    If so, explain_____
19. Are you pregnant…… ____ ____
20. Have you been pregnant in the last 6 months…… ____ ____

PATIENT UPDATE

Submit

I have filled out this Health Questionnaire completely. I have advised you of all problems of which I am aware.

I hereby certify that I have read the foregoing and have filled out this health Questionnaire completely. I have advised you of all medical problems of which I am aware. I further certify that I, the undersigned, consent to performing of x-rays, examination and whatever dental treatment may be agreed upon to be necessary or advisable.

_____ _____

SIGNATURE OF PATIENT OR PARENT IF PATIENT IS A MINOR **DATE**

SIGNATURE OF DOCTOR **DATE**