HEALTH QUESTIONNAIRE

Name _____ Birthdate _____

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 your 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

Bleeding, sore gums	Yes	No
Unpleasant taste/bad breath	Yes	No
Burning tongue/lips	Yes	No
Frequent blisters, lips/mouth	Yes	No
Swelling/lumps in mouth	Yes	No
Ortho treatments (braces)	Yes	No
Biting cheeks/lips	Yes	No
Clicking/popping jaw	Yes	No
Difficulty opening or closing jaw?	Yes	No

TEETH

Loose Teeth	Yes	No
Sensitive to hot	Yes	No
Sensitive to cold	Yes	No
Sensitive to sweets	Yes	No
Sensitive to biting	Yes	No
Food impaction	Yes	No
Clenching/grinding	Yes	No
If so, when _____		
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. Are you now under the care of a physician ..... Yes No
   If so, what is the condition being treated _____
3. The name and address of my physician is _____
   _____
4. Have you had any serious illness within the past (5) years ..... Yes No
   If so, what was the illness _____
5. Have you been hospitalized or had an operation within the last (5) years ..... Yes No
   If so, what was the problem _____
6. 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, coronary insufficiency, coronary occlusion, high/low blood pressure (arteriosclerosis, stroke, etc.)	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. Fainting spells or seizures	Yes	No
j. Diabetes	Yes	No
k. Hepatitis, jaundice or liver disease	Yes	No
l. Artificial or replacement joints, prosthetic	Yes	No

(over)

m. Tuberculosis ..... Yes No
n. Persistent cough or cough up blood ..... Yes No
o. Immune System disorders (including AIDS, HIV, ARC) ..... Yes No
p. Venereal Disease ..... Yes No
q. Other _____

7. Have you had abnormal bleeding associated with previous extractions, surgery or trauma ..... Yes No
   a. Have you ever required a blood transfusion ..... Yes No
      If so, explain the circumstances & when _____
8. Have you ever tested positive for the AIDS virus ..... Yes No
9. Do you have any blood disorder such as anemia ..... Yes No
10. Have you had surgery or x-ray treatment for a tumor, growth, or other condition ..... Yes No
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. Aspirin ..... Yes No
   e. Digitalis or drugs for heart trouble ..... Yes No
   f. Nitroglycerin ..... Yes No
   g. Other medications _____
   h. If "yes" to any of the above, state drug name, dosage and frequency _____
12. Are you allergic or have you reacted adversely to:
   a. Local anesthetics ..... Yes No
   b. Penicillin or other antibiotics ..... Yes No
   c. Aspirin ..... Yes No
   d. Iodine ..... Yes No
   e. Codeine or other narcotics ..... Yes No
   f. Other _____
13. Do you use any tobacco products ..... Yes No
   If so, how much per day and what _____
14. Do you have any disease, condition, or problem not listed above that you think I should know about ..... Yes No
   If so, explain _____
   _____

WOMEN

15. Are you pregnant ..... Yes No
16. 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

_____ _____
Initial Date Initial Date

_____ _____
Initial Date Initial Date

_____ _____
Initial Date Initial Date