



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. Circle **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 any 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 medicine Yes No or any recreational drugs (marijuana, cocaine, etc.)? Yes No
If so, what? _____ What dosage? _____
- Have you ever been pre-medicated with antibiotics for your dental treatment? Yes No
- Are you sensitive or allergic to any drugs? Penicillin; Tetracycline; Sulfa Drugs; Aspirin; Codeine;
 Other If Other, what drugs? _____
- Do you have or have you had any of the following: (Please check known conditions) Yes No

<input type="checkbox"/> Anemia	<input type="checkbox"/> Cold Sores	<input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Pain in Jaw Joints	<input type="checkbox"/> X-Ray or Cobalt Treatment
<input type="checkbox"/> Herpes	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Joint Replacement	<input type="checkbox"/> Respiratory Disease	<input type="checkbox"/> Fainting Spells or Seizures
<input type="checkbox"/> Stroke	<input type="checkbox"/> Rheumatism	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Nervous Disorders	<input type="checkbox"/> Sickle Cell Disease	<input type="checkbox"/> Chemotherapy (Cancer, Leukemia)
<input type="checkbox"/> Ulcers	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Tumors or Growths	<input type="checkbox"/> Tuberculosis (T.B.)	<input type="checkbox"/> Radiation Treatment of any kind
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Stomach Ulcers	<input type="checkbox"/> Allergies or Hives	<input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/> Hepatitis or Jaundice
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Head Injuries	<input type="checkbox"/> Angina Pectoris	<input type="checkbox"/> Cortisone Medicine	<input type="checkbox"/> Artificial Prosthesis	<input type="checkbox"/> Venereal Disease (Syphilis, Gonorrhea)
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Mental Disorder	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Psychiatric Treatment	<input type="checkbox"/> Acquired Immune Deficiency Syndrome (AIDS)
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Asthma	<input type="checkbox"/> Congenital Heart Lesions	<input type="checkbox"/> TMJ (Temporomandibular joint)
<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Difficulty in Swallowing	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Tonsillitis	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> AIDS Related Complex	<input type="checkbox"/> Heart Ailments or Attack	
<input type="checkbox"/> Mitral Valve Prolapse					
- Do you wear a cardiac pacemaker, or have you had heart surgery Yes No
- Do you have any disease, condition or problem not listed that you think I should know about? Yes No
If so, what? _____
- Do you smoke? If yes, how much? _____ per day Yes No
- (Women) Are you pregnant? If so how many months Yes No
- (Women) Do you have any problems associated with your menstrual period? Yes No
- (Women) Do you take birth control pills? Yes No
- Have you taken any Fen-Phen type diet medications such as Redux and Pondimin. Yes No
- Have you taken any Biophosphanate medications such as Fosamax, Boniva or Actonel Yes No

DENTAL HISTORY

- Have you ever had a local anesthetic (Novocaine, etc.)? Yes No
- Have you ever had any unfavorable reaction from a local anesthetic? Yes No
- Have you had any serious trouble associated with any previous dental treatment? Yes No
If so, explain _____
- How long since your last full mouth X-Rays? _____
- How long since your last dental treatment? _____
- Does dental treatment make you nervous Yes No
If Yes, Check : Slightly Moderately Extremely

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 if my medications change, I will, without fail, inform the doctor at my next appointment.

Date _____ Signature _____

Year 2
Changes in Health _____

Date _____ Signature _____

Year 3
Changes in Health _____

Date _____ Signature _____

Health Questionnaire MUST be updated every year!

REVIEWED BY	DO NOT WRITE IN THIS SPACE		
YEAR 1	Year 1	Year 2	Year 3
YEAR 2	Date	_____	_____
YEAR 3	BP	_____	_____
	Pulse	_____	_____
	Temp	_____	_____
	By	_____	_____

CONSENT FOR TREATMENT: I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

All services are rendered and accepted under the terms and conditions printed on the reverse hereof

Signed: _____ Date: _____

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

Relationship to the patient: _____