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

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 being treated? _____
4. Have you ever had any serious illness or operation? ..... Yes No
   If so, what illness or operation? _____
5. Have your even been hospitalized? ..... Yes No
   If so, what was the problem? _____
6. Are you taking any medicine ☐ Yes ☐ No or any recreational drugs (marijuana, cocaine, etc.)? ..... Yes No
   If so, what? _____ What dosage? _____
7. Have you ever been pre-medicated with antibiotics for your dental treatment? ..... Yes No
8. Are you sensitive or allergic to any drugs? ☐ Penicillin; ☐ Tetracycline; ☐ Sulfa Drugs; ☐ Aspirin; ☐ Codeine;
   ☐ Other If Other, what drugs? _____
9. Do you have or have you had any of the following: (Please check ✓ known conditions) ..... Yes No

☐ Anemia	☐ Cold Sores	☐ Sinus Trouble	☐ Blood Transfusion	☐ Pain in Jaw Joints	☐ X-Ray or Cobalt Treatment
☐ Herpes	☐ Hemophilia	☐ Blood Disease	☐ Joint Replacement	☐ Respiratory Disease	☐ Fainting Spells or Seizures
☐ Stroke	☐ Rheumatism	☐ Drug Addiction	☐ Nervous Disorders	☐ Sickle Cell Disease	☐ Chemotherapy (Cancer, Leukemia)
☐ Ulcers	☐ Heart Murmur	☐ Kidney Disease	☐ Tumors or Growths	☐ Tuberculosis (T.B.)	☐ Radiation Treatment of any kind
☐ Diabetes	☐ Bruise Easily	☐ Stomach Ulcers	☐ Allergies or Hives	☐ Epilepsy or Seizures	☐ Hepatitis or Jaundice
☐ Glaucoma	☐ Head Injuries	☐ Angina Pectoris	☐ Cortisone Medicine	☐ Artificial Prosthesis	☐ Venereal Disease (Syphilis, Gonorrhea)
☐ Arthritis	☐ Heart Failure	☐ Mental Disorder	☐ Excessive Bleeding	☐ Psychiatric Treatment	☐ Acquired Immune Deficiency Syndrome (AIDS)
☐ Emphysema	☐ Liver Disease	☐ Rheumatic Fever	☐ Asthma	☐ Congenital Heart Lesions	☐ TMJ (Temporomandibular joint)
☐ Hay Fever	☐ Scarlet Fever	☐ Thyroid Disease	☐ High Blood Pressure	☐ Difficulty in Swallowing	☐ Other: _____
☐ Tonsilitis	☐ Chicken Pox	☐ Cerebral Palsy	☐ AIDS Related Complex	☐ Heart Ailments or Attack	
☐ Mitral Valve Prolapse					

10. Do you wear a cardiac pacemaker, or have you had heart surgery ..... Yes No
11. Do you have any disease, condition or problem not listed that you think I should know about? ..... Yes No
    If so, what? _____
12. Do you smoke? If yes, how much? _____ per day ..... Yes No
13. (Women) Are you pregnant? If so how many months ..... Yes No
14. (Women) Do you have any problems associated with your menstrual period? ..... Yes No
15. (Women) Do you take birth control pills? ..... Yes No
16. Have you taken any Fen-Phen type diet medications such as Redux and Pondimin. ..... Yes No
17. Have you taken any Biophosphanate medications such as Fosamax, Boniva or Actonel ..... Yes No

DENTAL HISTORY

1. Have you ever had a local anesthetic (Novocaine, etc.)? ..... Yes No
2. Have you ever had any unfavorable reaction from a local anesthetic? ..... Yes No
3. Have you had any serious trouble associated with any previous dental treatment? ..... Yes No
   If so, explain _____
4. How long since your last full mouth X-Rays? _____
5. How long since your last dental treatment? _____
6. 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

_____ YEAR 1

_____ YEAR 2

_____ YEAR 3

DO NOT WRITE IN THIS SPACE

	Year 1	Year 2	Year 3
Date			
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: _____