HEALTH QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____

Family Physician: _____ Medical Specialist: _____

Are you under a physician's care? ☐ Yes ☐ No Describe: _____

Current height: _____ Current weight:_____ BP (to be entered by provider): _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No Describe: _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No Describe: _____

Any **allergies** to the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local anesthetic ☐ Latex
☐ Metal ☐ Acrylic ☐ Other: _____ ☐ No known drug allergies
Describe the reaction: _____

Please list any **medications** that you are taking:

☐ None

☐ Yes ☐ No --Do you regularly take herbal medicines or dietary supplements? Please Circle: Echinacea, Ephedra, Fish Oil, Garlic, Ginger, Ginkgo, Ginseng, St John's Wort, Tumeric, Other; _____

Do you have or have you ever had the following? Check all that apply. (*Condition may require premedication)				
□ ADHD	□ Cancer/ Chemotherapy	□ Glaucoma	□ Lung disease	□ Shingles
□ AIDS/HIV positive	□ Chest pains/angina	□ Headaches/migraines	□ Lupus	□ Sickle cell disease
□ Alzheimer's disease	□ Cold sores/fever blisters	□ Hearing/Vision impaired	□ Nursing	□ Sinus trouble (chronic)
□ Anemia	□ Congenital heart disorder	□ Heart attack/failure	□ Organ transplant*	□ Special needs (autism, etc)
□ Angina	□ Diabetes, type 1 or 2 Last A1C:____Date:_____	□ Heart murmur	□ Parkinson's	□ Spleen removed*
□ Arthritis	□ Easily winded	□ Heart pacemaker	☐ Currently Pregnant Due date: _____	□ Steroid therapy (oral cortisone, prednisone)
□ Artificial heart valve*	□ Emphysema/COPD	□ Heart disease (ie Mitral valve prolapse)	□ Psychiatric care (anxiety, depression, etc)	□ Stomach/intestinal disease
☐ Artificial joint: hip, knee, shoulder, _____	□ Endocarditis*	□ Hepatitis: A or B or C	□ Radiation treatments	□ Stroke
□ Asthma	□ Epilepsy	□ High/low blood pressure	□ Recent weight loss	□ Thyroid disease
□ Blood Disorder (Hemophilia, etc)	□ Excessive bleeding	□ Hypoglycemia	□ Renal dialysis	□ Tuberculosis
□ Blood transfusion	□ Excessive thirst	□ Kidney problems	□ Rheumatic fever	□ Tumors or growth
□ Breathing problem	□ Fainting spells/dizziness	□ Leukemia	□ Rheumatoid arthritis	□ Ulcers/ Colitis
□ Bulimia/anorexia	□ GERD/ Acid reflux	□ Liver disease	□ Seizures/ Convulsions	□ Venereal Disease/ Herpes/STD

☐ Yes ☐ No --Have you ever had any serious illness not mention above? If **yes**, please describe: _____

_____

☐ Yes ☐ No --Is your immune system suppressed by disease, medications or treatment?

☐ Yes ☐ No --Do you have any artificial joints? If **yes**, Circle type: hip knee shoulder other_____

a) How long have you had the prosthetic joint?(date of surgery) _____

b) Have you had any problems with the joint since it was replaced? Has it been replaced? ☐ Yes ☐ No

☐ Yes ☐ No --Are you taking any blood thinners?

☐ Yes ☐ No --Have you **ever** received osteoporosis therapy or medication to reduce high blood calcium?
(ie. Actonel, Aredia, Boniva, Calciman, Denosumab, Fosamax, Xgeva, Zometa):

☐ Yes ☐ No --Do you use tobacco? If **no**, skip to next question

-Cigarette Smoking:

Smoke(d) □ less than 10 cigs/day □ Smoke(d) less than 10 years Quit □ less than 10 years ago
□ 10 or more cigs/day □ 10 or more years □ 10 or more years ago

-Pipes/Cigars :

Smoke(d) □ less than 10 cigs/day Smoke(d) □ less than 10 years Quit □ less than 10 years ago
□ 10 or more cigs/day □ 10 or more years □ 10 or more years ago

-Smokeless (Chewing) Tobacco: □ Never Used

Use: □ Occasional Use Use: □ less than 10 years Quit □ less than 10 years ago
□ Daily Use □ 10 or more years □ 10 or more years ago

-If **yes**, how interested are you in quitting your tobacco use? □ Very interested □ Somewhat interested □ Not at all

☐ Yes ☐ No --Do you drink sugared beverages? If **yes**, how many per day? _____ Per week? _____

☐ Yes ☐ No --Do you drink Alcohol? If **yes**, Average number of drinks consumed in the past year?
□ None □ Less than 1 drink per day □ 2 drinks per day □3 or more drinks per day

☐ Yes ☐ No --Are you or have you ever had a drug/alcohol addiction?
-If **yes**, what kind? ex. Alcohol, prescription drugs, heroine, meth, cocaine, marijuana, or other_____

Dental History

Previous family dentist _____
Do you have any dental concerns? □ Yes □ No
Describe: _____
Date of last complete dental exam: _____
Have you ever had orthodontic treatment (braces)? □ Yes □No
Have you ever been treated for gum disease? □ Yes □ No
Do your gums bleed when you brush your teeth? □ Yes □ No
Do you grind your teeth? □ Yes □ No
Do you have toothaches? □ Yes □ No
Do you have frequent sores in your mouth? □ Yes □ No
Have you had any injuries to your mouth or jaw? □ Yes □ No
If so, explain: _____
Do you have any sores/swelling of your mouth or jaws?
□ Yes □ No
Are you interested in keeping your teeth? □ Yes □ No
Do you have any dental implants? □ Yes □ No
Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____
Signature of patient, parent, or guardian

_____
Today's Date

_____
Dentist's Signature

Rev 9/2019