HEALTH QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____

Family Physician: _____ Medical Specialist: _____

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

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

Do you have or have you ever had the following? Check all that apply (*Condition may require premedication)

- ☐ Have you ever been hospitalized or had a major operation? Describe: _____ _____
- ☐ Addiction: drug/alcohol
- ☐ ADHD
- ☐ AIDS/HIV positive
- ☐ Alzheimer's disease
- ☐ Anemia
- ☐ Angina/ chest pain
- ☐ Arthritis
- ☐ Artificial heart valve *
- ☐ Artificial joint (please check): * Hip☐Knee☐Shoulder _____ Date of surgery: _____ Has the joint been replaced: ____
- ☐ Asthma
- ☐ Blood disorder (Hemophilia, etc.)
- ☐ Blood Transfusion
- ☐ Breastfeeding, currently
- ☐ Breathing problems
- ☐ Bulimia/ anorexia
- ☐ Cancer/ Chemotherapy
- ☐ Cold sores/ fever blister
- ☐ Congenital heart disorder
- ☐ Diabetes, type 1 or 2 Last A1c:_____ Date:_____
- ☐ Easily winded
- ☐ Emphysema/ COPD
- ☐ Endocarditis *
- ☐ Excessive bleeding
- ☐ Excessive thirst
- ☐ Fainting spells/ dizziness
- ☐ GERD/ Acid reflux
- ☐ Glaucoma
- ☐ Headaches/ migraines
- ☐ Hearing impaired
- ☐ Heart attack/ failure
- ☐ Heart murmur
- ☐ Heart pacemaker
- ☐ Heart disease (i.e. Mitral valve prolapse, etc.)
- ☐ Hepatitis: A, B or C (please circle)
- ☐ High/low blood pressure
- ☐ Hypoglycemia
- ☐ Kidney problems
- ☐ Leukemia
- ☐ Liver disease
- ☐ Lung disease
- ☐ Lupus
- ☐ Multiple Sclerosis
- ☐ Organ transplant *
- ☐ Parkinson's disease
- ☐ Pregnant, currently; Due date:_____
- ☐ Psychiatric care (anxiety, depression, etc.)
- ☐ Radiation treatment
- ☐ Recent weight loss
- ☐ Renal dialysis
- ☐ Rheumatic fever
- ☐ Rheumatoid arthritis
- ☐ Seizures/ Convulsions/ Epilepsy
- ☐ Shingles
- ☐ Sickle cell disease
- ☐ Sinus trouble (chronic)
- ☐ Special needs (autism, etc.)
- ☐ Spleen removed
- ☐ Steroid therapy (oral cortisone, prednisone)
- ☐ Stomach/intestinal disease
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Tumors or growths
- ☐ Ulcers/ Colitis
- ☐ Venereal disease/ Herpes/ STDs
- ☐ Vision impaired
- ☐ Any other serious illness not mentioned above: _____

MEDICATIONS:

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

☐ 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: _____

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

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

☐ None

ADULTS:

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

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

-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

- □ Vaping

☐ 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?

□ Less than 1 drink per day □ 2 drinks per day □ 3 or more drinks per day

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 head/neck? □ 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

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