

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 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 had any of the following?

MOUTH	TEETH				
Bleeding, sore gums	Loose teeth	Yes	No	Yes	No
Unpleasant taste/bad breath	Sensitive to hot	Yes	No	Yes	No
Burning tongue/lips	Sensitive to cold	Yes	No	Yes	No
Frequent blisters, lips/mouth	Sensitive to sweets	Yes	No	Yes	No
Swelling/lumps in mouth	Sensitive to biting	Yes	No	Yes	No
Ortho treatments (braces)	Food impaction	Yes	No	Yes	No
Biting cheeks/lips	Clenching/grinding	Yes	No	Yes	No
Clicking/popping jaw	If so, when _____	Yes	No		
Difficulty opening or closing jaw	Change in bite	Yes	No	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 changes in your general health within the past year Yes No
2. My last physical examination was on _____
3. Are you now under the care of a physician Yes No
If so, what is the condition being treated _____
4. The name and address of my physician is _____
5. Have you had any serious illness within the past five (5) years Yes No
If so, what was the illness _____
6. Have you been hospitalized or had an operation within the past five (5) years Yes No
If so, what was the problem _____
7. 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
1) Do you have pain in chest upon exertion	Yes	No
2) Are you ever short of breath after mild exercise	Yes	No
3) Do your ankles swell	Yes	No
4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep	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. Hives or a skin rash	Yes	No
j. Fainting spells or seizures	Yes	No
k. Diabetes	Yes	No
1) Do you have to urinate (pass water) more than six times a day	Yes	No
2) Are you thirsty much of the time	Yes	No
3) Does your mouth frequently become dry	Yes	No

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| l. Hepatitis, jaundice or liver disease | Yes | No |
| m. Arthritis or inflammatory rheumatism | Yes | No |
| n. Artificial or replacement joints, prosthetic | Yes | No |
| o. Digestive system – Ulcers or stomach disorders (colitis) | Yes | No |
| p. Kidney trouble | Yes | No |
| q. Tuberculosis | Yes | No |
| r. Persistent cough or cough up blood | Yes | No |
| s. Immune System disorders (including AIDS, HIV, ARC) | Yes | No |
| t. Venereal disease | Yes | No |
| u. Other _____ | | |
| 8. Have you ever had abnormal bleeding associated with previous extractions, surgery, or trauma | Yes | No |
| a. Do you bruise easily | Yes | No |
| b. Have you ever required a blood transfusion | Yes | No |
| If so, explain the circumstances & when _____ | | |
| 9. Have you ever tested positive for the AIDS virus | Yes | No |
| 10. Do you have any blood disorder such as anemia | Yes | No |
| 11. Have you had surgery or x-ray treatment for a tumor, growth, or other condition | Yes | No |
| 12. 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. Cortisone (steroids) | Yes | No |
| e. Tranquilizers | Yes | No |
| f. Antihistamines | Yes | No |
| g. Aspirin | Yes | No |
| h. Insulin, tolbutamide (Orinase) or similar drug for diabetes | Yes | No |
| i. Digitalis or drugs for heart trouble | Yes | No |
| j. Nitroglycerin | Yes | No |
| k. Other medications _____ | | |
| l. If “Yes” to any of the above, state drug name, dosage and frequency _____ | | |
| 13. Are you allergic or have you reacted adversely to: | | |
| a. Local anesthetics | Yes | No |
| b. Penicillin or other antibiotics | Yes | No |
| c. Sulfa drugs | Yes | No |
| d. Barbiturates, sedatives, or sleeping pills | Yes | No |
| e. Aspirin | Yes | No |
| f. Iodine | Yes | No |
| g. Codeine or other narcotics | Yes | No |
| h. Other _____ | | |
| 14. Do you use any tobacco products | Yes | No |
| If so, now much per day and what _____ | | |
| 15. Do you use any alcohol products | Yes | No |
| If so, how much per day/week/month and what _____ | | |
| 16. Do you use any caffeinated products (coffee, tea, chocolate, etc.) | Yes | No |
| If so, now much per day and what _____ | | |
| 17. Do you have any disease, condition, or problem not listed above that you think I should know about | Yes | No |
| If so, explain _____ | | |
| 18. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation | Yes | No |
| 19. Are you wearing contact lenses | Yes | No |
| 20. Are you experiencing stress or pressure in your work or at home | Yes | No |

WOMEN

- | | | |
|--|-----|----|
| 21. Are you pregnant | Yes | No |
| 22. Do you have PMS or problems associated with you menstrual period | Yes | No |
| 23. 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

Signature of Dentist

Date