HEALTH QUESTIONAIRE

PATIENT NAME _____ DATE OF BIRTH _____

Please describe your reason(s) for today's visit _____

Doctors name and contact information.

Are you under physician care now? ☐ Yes ☐ No _____

Have you ever been hospitalized or had a major surgery? ☐ Yes ☐ No If yes, please explain_ _____

Have you had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain _____

Do you smoke, use controlled substances, or pain medications? ☐ Yes ☐ No If yes, please list _____

Are you currently taking any medications? ☐ Yes ☐ No If yes, please list _____

Have you ever taken Bisphosphonates or Fosamax? ☐ Yes ☐ No IV or Pills? _____

Are you on a special diet? ☐ Yes ☐ No If yes, please explain _____

Women are you:
Pregnant or trying to get pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No
Taking oral contraceptives? ☐ Yes ☐ No If yes, please list

Are you allergic to any of the following?

☐ Aspirin ☐ Codeine ☐ Penicillin ☐ Acrylic or Latex ☐ Metal ☐ Local Anesthetics ☐ Other

If yes, please explain _____

Do you have, or have you had, any of the following?

☐ Aids/HIV	☐ Chest Pain	☐ Genital Herpes	☐ Irregular Heartbeat	☐ Shingles
☐ Alzheimer's Disease	☐ Cold Sores/Blister	☐ Glaucoma	☐ Kidney Problems	☐ Sickle Cell Disease
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Hay Fever	☐ Liver Disease	☐ Cleft Lip/Palate
☐ Anemia	☐ Cortisone Medications	☐ Headaches	☐ Low Blood Pressure	☐ Sinus Trouble
☐ Angina	☐ Diabetes	☐ Heart Attack/Failure	☐ Lung Disease	☐ Spina Bifida
☐ Arthritis	☐ Drug Addiction	☐ Heart Disease	☐ Mitral Valve Prolapse	☐ Stomach Disease
☐ Artificial Heart Valve	☐ Easily Winded	☐ Heart Murmur	☐ Pain/Locking Jaw Joint	☐ Stroke
☐ Artificial Joint	☐ Emphysema	☐ Heart Pacemaker	☐ Parathyroid Disease	☐ Swelling (limbs)
☐ Asthma	☐ Epilepsy, Seizures	☐ Hemophilia/Clotting Disorders	☐ Psychiatric Care/Depression	☐ Thyroid Disease
☐ Blood Disease	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tuberculosis
☐ Bruise Easily	☐ Fainting /Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatism	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Scarlet Fever	☐ Other Serious Illness

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 the patient's health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____

Patient or Parent/Guardian Signature *Date*