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 you 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 a bad experience 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. Do you have or have you ever had any of the following?

Mouth			Teeth		
Bleeding, sore gums.....	Yes	No	Loose teeth.....	Yes	No
Unpleasant taste/bad breath.....	Yes	No	Sensitive to hot.....	Yes	No
Burning tongue/lips.....	Yes	No	Sensitive to cold.....	Yes	No
Frequent blisters, lips/mouth.....	Yes	No	Sensitive to sweets.....	Yes	No
Swelling/lumps in mouth.....	Yes	No	Sensitive to biting.....	Yes	No
Ortho treatments (braces).....	Yes	No	Food impaction.....	Yes	No
Biting cheeks/lips.....	Yes	No	Clenching/grinding.....	Yes	No
Clicking/popping jaw.....	Yes	No	If so, when _____		
Difficulty opening or closing jaw....	Yes	No	_____		

7. Is there anything you would like to improve with your smile and/or teeth? _____

_____

Medical

1. Has there been any change in you general health within the past year? ..... Yes No
2. 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 physician _____

_____
5. Have you had any serious illness within the past five (5) years..... Yes No

   If so, what is 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. Are you currently taking any medications or drugs..... Yes No

   If so, please list_____
8. Are you allergic to any medications or drugs ..... Yes No

   If so, please list_____
9. Do you need to be premedicated for any reason ..... Yes No

   If so, please list_____

Please continue on reverse side

HEALTH QUESTIONNAIRE CONTINUED

10. Indicate which of the following you have had or have at present, circle "Yes" or "No" to each item.

Heart Failure........................	Yes	No	Latex Allergy.........................	Yes	No	AIDS.....................................	Yes	No
Heart Disease or Attack.....	Yes	No	Emphysema.........................	Yes	No	Hepatitis A (infectious).......	Yes	No
Angina Pectoris..................	Yes	No	Cough...................................	Yes	No	Hepatitis B (serum)............	Yes	No
High Blood Pressure............	Yes	No	Asthma................................	Yes	No	Liver Disease........................	Yes	No
Heart Murmur.......................	Yes	No	Hay Fever.............................	Yes	No	Yellow Jaundice..................	Yes	No
Heart Surgery.......................	Yes	No	Sinus Trouble.......................	Yes	No	Blood Transfusion................	Yes	No
Congenital Heart Lesions....	Yes	No	Allergies or Hives................	Yes	No	Hemophilia...........................	Yes	No
Artificial Heart Valve............	Yes	No	Cosmetic Surgery.................	Yes	No	Anemia.................................	Yes	No
Heart Pacemaker................	Yes	No	Tuberculosis (TB)..................	Yes	No	Sickle Cell Disease...............	Yes	No
Stroke...................................	Yes	No	Cortisone Medicine..............	Yes	No	Epilepsy or Seizures.............	Yes	No
Rheumatic Fever..................	Yes	No	Cold Sores............................	Yes	No	Drug Addiction.....................	Yes	No
Scarlet Fever.........................	Yes	No	Ulcers...................................	Yes	No	Psychiatric Treatment.........	Yes	No
Bruise Easily.........................	Yes	No	Kidney Trouble.....................	Yes	No	Fainting or Dizzy Spells........	Yes	No
Thyroid Disease....................	Yes	No	Nervousness.........................	Yes	No	Tissue Biopsy........................	Yes	No
Glaucoma..............................	Yes	No	Pain in Jaw Joints................	Yes	No	Cancer..................................	Yes	No
Diabetes	Yes	No	Genital Herpes......................	Yes	No	Growth or Tumor..................	Yes	No
Rheumatism	Yes	No	Venereal Disease................	Yes	No	Chemo Therapy....................	Yes	No
Artificial Joints......................	Yes	No	(Syphilis, Gonorrhea)			(Cancer, Leukemia)		

11. Do you have any disease, condition, or problem not listed.. Yes No

If so, please list ____

12. **WOMEN:** Are you pregnant now.. Yes No

If so, what month____

Are you practicing birth control... Yes No

Do you anticipate becoming pregnant.. Yes No

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 inform the doctor of dentistry at the next appointment without fail.

____ _______________________

Signature of Patient, Parent or Guardian Date Staff Signature/Initials

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MEDICAL HISTORY/PHYSICAL EVALUATION UPDATE

DATE	HEALTH HISTORY CHANGES	NEW MEDICATIONS	PATIENT SIGNATURE
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