| | Blood Pressure | Date |
|---|---|---|
| Year 1 | | |
| Year 2 | | |
| Year 3 | | |

Insurance

# HEALTH QUESTIONNAIRE

| Name | Date of Birth | Acct # |
|---|---|---|
| | | |

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental concern, but they are all associated with proper oral health care. Please answer each question and mark YES or NO as appropriate

MEDICAL HISTORY Email: _____ Yes No

1. Are you in good health? ..... ☐ ☐
2. Are you now under the care of a physician? ..... ☐ ☐
   If so, what is the condition being treated? _____
   Physician name / phone # / address _____
3. Have you ever had any serious illness or operation? ..... ☐ ☐
   If so, what illness or operation? _____
4. Have you ever been hospitalized? ..... ☐ ☐
   If so, what was the problem? _____
5. Are you taking medicine? ☐ Yes ☐ No or any recreational drugs (marijuana, cocaine, etc.) ..... ☐ ☐
   If so, what? _____ What dosage? _____
6. Are you sensitive or allergic to any drugs? ☐ Penicillin ☐ Tetracycline ☐ Sulfa Drugs ☐ Aspirin ☐ Codeine ☐ ☐
   Other: If other, what drug(s)? _____
7. Do you have, or have you had, any of the following:

| Yes | No | | Yes | No | | Yes | No | | Yes | No | | Yes | No | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Heart Murmur | ☐ | ☐ | Joint Replacement | ☐ | ☐ | Epilepsy or Seizures | ☐ | ☐ | Anemia | ☐ | ☐ | Liver Disease |
| ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Allergies or Hives | ☐ | ☐ | Heart Ailments or Attack | ☐ | ☐ | Ulcers | ☐ | ☐ | Sinus Trouble |
| ☐ | ☐ | Radiation Therapy | ☐ | ☐ | Cortisone Medicine | ☐ | ☐ | Hepatitis or Jaundice | ☐ | ☐ | Glaucoma | ☐ | ☐ | Blood Disease |
| ☐ | ☐ | Rheumatic Fever | ☐ | ☐ | Excessive Bleeding | ☐ | ☐ | Fainting Spells or Seizures | ☐ | ☐ | Arthritis | ☐ | ☐ | Drug Addiction |
| ☐ | ☐ | Tuberculosis (T.B.) | ☐ | ☐ | AIDS Related Complex | ☐ | ☐ | Chemotherapy (Cancer, Leukemia) | ☐ | ☐ | Emphysema | ☐ | ☐ | Kidney Disease |
| ☐ | ☐ | Cardiac Pacemaker | ☐ | ☐ | Pain in Jaw Joints | ☐ | ☐ | Venereal Disease (Syphilis, Gonorrhea) | ☐ | ☐ | Cold Sores | ☐ | ☐ | A.I.D.S. |
| ☐ | ☐ | Nervous Disorders | ☐ | ☐ | Respiratory Disease | ☐ | ☐ | Artificial Prosthesis | ☐ | ☐ | Bruise Easily | ☐ | ☐ | Asthma |
| ☐ | ☐ | Thyroid Disease | ☐ | ☐ | Mental Disorder | ☐ | ☐ | Angina Pectoris | ☐ | ☐ | Head Injuries | ☐ | ☐ | Hemophilia |
| ☐ | ☐ | Tumors or Growths | ☐ | ☐ | Psychiatric Treatment | ☐ | ☐ | Congenital Heart Lesions | ☐ | ☐ | Diabetes | ☐ | ☐ | Stroke |
| ☐ | ☐ | Blood Transfusion | ☐ | ☐ | Cerebral Palsy | ☐ | ☐ | Heart Surgery (Valve Replacement) | ☐ | ☐ | Prosthetic Joints | | | |
| | | | ☐ | ☐ | BISPHOSPHONATE THERAPY | | | | | | | | | |

Yes No

8. Do you have any disease, condition or problem not listed that you think we should know about? ..... ☐ ☐
   If so, what? _____
9. Do you smoke? If yes, how much per day? ..... ☐ ☐
10. **(Women)** Is there a possibility you may be pregnant? ..... ☐ ☐
11. **(Women)** Do you have any problems associated with your menstrual period? ..... ☐ ☐
12. **(Women)** Do you take birth control pills? ..... ☐ ☐

DENTAL HISTORY

1. Have you ever had a local anesthetic (Novocaine, etc.)? ..... ☐ ☐
2. Have you ever had any unfavorable reaction from a local anesthetic? ..... ☐ ☐
3. Have you had any serious trouble associated with any previous dental treatment? ..... ☐ ☐
   If so, explain _____
4. How long since your last full mouth x-rays? _____
5. How long since your last dental treatment? _____
6. Is any current dental problem the result of an accident? ☐ YES ☐ NO WHEN? _____
7. Does dental treatment make you nervous? ☐ No ☐ Slightly ☐ Moderately ☐ Extremely

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, without fail, inform the doctor at my next appointment.

Patient Signature: _____ Date: _____ DDS Signature: _____ Date: _____

Year 2 Change in Health: _____ ☐ None

Patient Signature _____ Date: _____ DDS Signature: _____ Date: _____

Year 3 Change in Health: _____ ☐ None

Patient Signature: _____ Date: _____ DDS Signature: _____ Date: _____

## DDS NOTES