Health Questionnaire

To ensure your well being while undergoing treatment in our office, please answer the following questions in detail. Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. All answers will be held in strict confidence. Personal medical records will not be released to anyone without your written authorization.

Name (please print): _____ Birth Date: _____

Physician's Name: _____ Physician's Phone: _____

Medical History

		YES	*(if yes please explain)*	NO
1.	Have you ever experienced shortness of breath or chest pain?	☐	_____	☐
2.	Have you been a patient in a hospital in the last two years?	☐	_____	☐
3.	Have you been under a physician's care during the past two years?	☐	_____	☐
4.	Do you take, or have you taken Phen-Fen?	☐	_____	☐
5.	Do you take, or have you taken any medication for osteoporosis such as Bisphosphonate? If yes, please list.	☐	_____	☐
6.	Have you experienced anemia, hemophilia or any other blood disorders? **If yes, are you taking any blood thinners (i.e. aspirin, coumadin)?**	☐	_____	☐
7.	Are you taking any medications or drugs? **If yes, please indicate which ones:**	☐	*(indicate meds on line below)*	☐

_____

8. Are you allergic to or have you reacted adversely to any medication, drug or latex? ☐ Yes ☐ No

If yes, please indicate your allergy: _____

9. Do you smoke or chew tobacco? ☐ Yes ☐ No

10. Women: Are you pregnant or may you be pregnant? ☐ Yes ☐ No Due Date: _____
Are you nursing? ☐ Yes ☐ No
Are you taking any contraceptive? ☐ Yes ☐ No

11. Check any of the following which you may have had:

- ☐ AIDS/HIV Positive
- ☐ Alcoholism or Drug Addiction
- ☐ Angina
- ☐ Arthritis/Gout / Rheumatism
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Bruise Easily
- ☐ Cancer
  - If yes, when? _____
  - What Kind? _____
- ☐ Chemotherapy or Radiation
  - Treatment Dates: _____
- ☐ Cold Sores / Fever Blisters
- ☐ Diabetes
- ☐ Epilepsy or Seizures
- ☐ Fainting Spells or Dizziness
- ☐ Glaucoma
- ☐ Heart Attack / Failure / Disease
- ☐ Heart Murmur/Irregular Heartbeat
- ☐ Heart Pacemaker / Prosthesis
- ☐ Hemophilia
- ☐ Hepatitis: Type? A / B / C
- ☐ Herpes
- ☐ High or Low Blood Pressure
- ☐ Hypoglycemia
- ☐ Joint Replacement, Pins
- ☐ Kidney Disease
  - If yes, Dialysis? ☐ Yes ☐ No
  - When? _____
- ☐ Liver Disease
- ☐ Lung Disease / Emphysema
- ☐ Osteoporosis
- ☐ Pain in Jaw Joints
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shingles/ Skin Rash/ Hives
- ☐ Shortness or Difficulty Breathing
- ☐ Sinus Trouble
- ☐ Stroke
- ☐ Thyroid or Parathyroid Disease
- ☐ Tuberculosis
- ☐ Tumors or Abnormal Growths
- ☐ Ulcers
- ☐ Venereal Disease

Have you ever had any other medical condition or serious illness not listed above? If yes, please explain. _____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or insufficient information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient/ Parent or Legal Guardian Signature: _____ **Date:** _____

Doctor's Signature: _____ **Date:** _____