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HEALTH QUESTIONNAIRE

Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

| | | | |
|--|------------------|---------------------|--|
| Name: | Date of birth: | Phone: | <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Physician: | Physician Phone: | Date of last visit: | |
| If you are completing this form for another person, what is your relationship to the person? | | | |

| | | | |
|----|--|---------------------------------|--------------------------------|
| 1. | Are you currently under the care of a physician? If yes, what is the condition being treated? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 2. | Have you had any serious illness, operation, or been hospitalized within the past 5 years? If yes, what was the illness or problem? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 3. | Are you currently taking, or have you taken within the last week, any over-the-counter medicines? If yes, what medicines? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 4. | Have you ever taken the diet control drug Fen-Phen? If yes, for how long? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |

| 5. | Are you allergic to, or have you reacted adversely to, any of the following: | YES | NO | Comments: |
|----|--|--------------------------|--------------------------|-----------|
| | Local anesthetics | <input type="checkbox"/> | <input type="checkbox"/> | |
| | Penicillin/tetracycline/other antibiotics | <input type="checkbox"/> | <input type="checkbox"/> | |
| | Sulfa drugs | <input type="checkbox"/> | <input type="checkbox"/> | |
| | Barbiturates/sedatives/sleeping pills | <input type="checkbox"/> | <input type="checkbox"/> | |
| | Aspirin | <input type="checkbox"/> | <input type="checkbox"/> | |
| | Codeine/other narcotics | <input type="checkbox"/> | <input type="checkbox"/> | |
| | Iodine | <input type="checkbox"/> | <input type="checkbox"/> | |
| | Metals (e.g., nickel, mercury, metal jewelry, etc.) | <input type="checkbox"/> | <input type="checkbox"/> | |
| | Latex rubber | <input type="checkbox"/> | <input type="checkbox"/> | |
| | Other, please list: | <input type="checkbox"/> | <input type="checkbox"/> | |

| 6. Do you now have, or have you ever had, any of the following: | | | | | | | | |
|---|--------------------------|--------------------------|-------------------------|--------------------------|--------------------------|------------------------------|--------------------------|--------------------------|
| | YES | NO | | YES | NO | | YES | NO |
| High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | Environmental allergies | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Low blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | Asthma/ hay fever | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| Chest pain upon exertion | <input type="checkbox"/> | <input type="checkbox"/> | Sinus trouble | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> | <input type="checkbox"/> |
| Shortness of breath | <input type="checkbox"/> | <input type="checkbox"/> | Hives/skin rash | <input type="checkbox"/> | <input type="checkbox"/> | Bronchitis | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting spells/seizures | <input type="checkbox"/> | <input type="checkbox"/> | Unusual weight loss | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic heart disease | <input type="checkbox"/> | <input type="checkbox"/> | Persistent diarrhea | <input type="checkbox"/> | <input type="checkbox"/> | Sexually transmitted disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic fever | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | AIDS/HIV infection | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart attack/stroke | <input type="checkbox"/> | <input type="checkbox"/> | Urinate frequently | <input type="checkbox"/> | <input type="checkbox"/> | Alcohol/drug abuse | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart disease/angina | <input type="checkbox"/> | <input type="checkbox"/> | Frequently dry mouth | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> |
| Damaged heart valve | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis/jaundice | <input type="checkbox"/> | <input type="checkbox"/> | Anemia/leukemia | <input type="checkbox"/> | <input type="checkbox"/> |
| Cardiac pacemaker | <input type="checkbox"/> | <input type="checkbox"/> | Liver disease | <input type="checkbox"/> | <input type="checkbox"/> | Blood clotting problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart murmur | <input type="checkbox"/> | <input type="checkbox"/> | Gall bladder trouble | <input type="checkbox"/> | <input type="checkbox"/> | Cancer /tumor or growth | <input type="checkbox"/> | <input type="checkbox"/> |
| Mitral valve prolapse | <input type="checkbox"/> | <input type="checkbox"/> | Kidney/bladder trouble | <input type="checkbox"/> | <input type="checkbox"/> | Anorexia/bulimia | <input type="checkbox"/> | <input type="checkbox"/> |
| Ankles swell | <input type="checkbox"/> | <input type="checkbox"/> | Stomach ulcers | <input type="checkbox"/> | <input type="checkbox"/> | Frequent headaches | <input type="checkbox"/> | <input type="checkbox"/> |
| Joint replacement | <input type="checkbox"/> | <input type="checkbox"/> | Mental health problems | <input type="checkbox"/> | <input type="checkbox"/> | Color blindness | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood transfusion | <input type="checkbox"/> | <input type="checkbox"/> | Contact lenses | <input type="checkbox"/> | <input type="checkbox"/> | | | |

| 7. Please list any prescription medications you are currently taking: | | |
|---|-----------------|--------------------------|
| Medication Name | # of Milligrams | # of Tablets Taken Daily |
| | | |
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| | | |
| | | |
| | | |

| WOMAN ONLY: | | YES | NO |
|-------------|--|--------------------------|--------------------------|
| 8. | Are you pregnant? If yes, what is your due date: | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. | Are you currently nursing? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | Do you have any problems associated with your menstrual period? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. | Are you on hormone replacement therapy? Please list: | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. | 12. Are you on birth control pills/fertility drugs? Please list: | <input type="checkbox"/> | <input type="checkbox"/> |

| DENTAL HISTORY: | | | |
|-----------------|---|--|--------------------------|
| 13. | Date of your last cleaning: | Last exam: | |
| 14. | Date of your last full series x-rays: | Last cavity detection (bitewing) x-rays: | |
| 15. | Name of dentist you saw? | YES | NO |
| 16. | Do your gums bleed while brushing or flossing? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. | Are your teeth sensitive to hot, cold, or sweets? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. | Do you get frequent fever blisters, mouth ulcers, or sores on your lips or in your mouth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. | Have you ever had burning of the tongue or cracking of the corners of your mouth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. | Do you chew or smoke tobacco in any form? Please list: what and how much/day: | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. | Have you had any head, neck, or jaw injuries? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. | Do you notice popping, clicking, or soreness of the jaws or points just in front of the ears? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. | Do you clench or grind your teeth? If yes, when: | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. | Have you had any serious trouble associated with any previous dental treatment? If yes, please explain: | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. | Have you ever had orthodontic treatment? If yes, date of placement: | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. | Do you wear dentures or partials? If yes, date of placement:: | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. | Are you having any specific problems with your teeth, gums, or mouth at this time? If yes, please explain: | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. | Are you happy with your smile? | <input type="checkbox"/> | <input type="checkbox"/> |

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her team, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient/Parent: _____ Date: _____

I do hereby authorize the release of any pertinent information regarding my medical or dental history to other healthcare professionals, as deemed necessary by this office

Signature of Patient/Parent: _____ Date: _____

| MEDICAL HISTORY UPDATE: | | | |
|-------------------------|---------------------------|-------|---------------------------|
| Date: | Patient/Parent Signature: | Date: | Patient/Parent Signature: |
| | | | |
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