

HEALTH HISTORY QUESTIONNAIRE

It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

NAME (Last, First, MI.) _____ Birthdate _____

PERSONAL HEALTH HISTORY

Do you smoke or use Tobacco in any other form? Yes <input type="checkbox"/> No <input type="checkbox"/>	Have you ever taken Fosamax, Actonel, Boniva or any other bisphosphonate? Yes <input type="checkbox"/> No <input type="checkbox"/>	Have you ever taken any dietary supplements such as Fen-Phen/Redux? Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you drink excessively Yes <input type="checkbox"/> No <input type="checkbox"/>	ARE YOU ALLERGIC TO OR HAVE REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS? (CIRCLE) YES NO <input type="checkbox"/> <input type="checkbox"/> Aspirin Local Anesthetic Erythromycin Penicillin Codeine Latex Are you aware of being allergic to any other medications <input type="checkbox"/> <input type="checkbox"/> Or substances? if yes, please list: _____	For Women: YES NO <input type="checkbox"/> <input type="checkbox"/> Are you pregnant? <input type="checkbox"/> <input type="checkbox"/> Are you nursing? <input type="checkbox"/> <input type="checkbox"/> Are you using any type of birth control? <input type="checkbox"/> <input type="checkbox"/>

DENTAL HISTORY

HOW LONG SINCE you have seen a dentist _____ YES NO
 Last COMPLETE Dental Exam, Date _____
 Are you having PROBLEMS now?
 WHAT? _____
 Are you currently in PAIN?
 Do you wear DENTURES? (Partials or Full)
 Are you APPREHENSIVE about dental treatment?
 Do your gums BLEED, SORE, SWOLLEN or TENDER or IRRITATED?
 Are your teeth SENSITIVE To hot, cold, sweets, pressure? (circle)
 Are your teeth loose?
 Are you UNHAPPY with the APPEARANCE of your teeth?
 Are you aware of GRINDING or CLENCHING your teeth?
 Have you worn BRACES on your teeth (ORTHODONTICS)
 Do you have DISCOLORED teeth that bother you?
 Would you like your smile to LOOK BETTER or DIFFERENT?
 Do you REGULARLY use DENTAL FLOSS?

MEDICAL HISTORY

Do you have CURRENT HEALTH PROBLEMS?
 Are you under PHYSICIAN'S CARE now?
 For WHAT? _____
 Have you had surgery?
 If so, Please Specify _____
 Do you have numbness or pain in the FACE/NECK/MOUTH
 Do you have sore or lesion on lips or mouth for more than 2 wks
 Do you have chronic hoarseness
 Do you have lump or thickening in the cheek
 Do you snore or have you been told you snore?
 Is there a history of heart disease in your immediate fami
 Do you have a family history of diabetes?

MEDICAL HISTORY

PLEASE ✓ YES OR NO OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

	YES	NO		YES	NO
AIDS/HIV Pos.	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Anaphylaxis	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis (Rheumatism)	<input type="checkbox"/>	<input type="checkbox"/>	Jaw pain	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valves	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease or malfunction	<input type="checkbox"/>	<input type="checkbox"/>
Artificial joints	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Atopic (allergy prone)	<input type="checkbox"/>	<input type="checkbox"/>	Nervous problems	<input type="checkbox"/>	<input type="checkbox"/>
Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker/heart surgery	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric care	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Rapidweight gain/loss	<input type="checkbox"/>	<input type="checkbox"/>
Chemical dependency	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory disease	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory problems	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic/scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone treatments	<input type="checkbox"/>	<input type="checkbox"/>	Shingles	<input type="checkbox"/>	<input type="checkbox"/>
Cough (persistent)	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Cough up blood	<input type="checkbox"/>	<input type="checkbox"/>	Skin rash	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Spina Bifida	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Food Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Surgical Implant	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of feet/ankles	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease/malfunction	<input type="checkbox"/>	<input type="checkbox"/>
Heart problems (pls describe) _____	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
Hemophilia (abnormal bleeding) _____	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer Colitis	<input type="checkbox"/>	<input type="checkbox"/>
Is there any other Medical or dental info that you feel I should know about _____	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform the office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature (patient or paprent/guardian) _____ Date _____

Doctor's Signature _____ Date _____

