PATIENT NAME _____ (LAST) _____ (FIRST)

HEALTH QUESTIONNAIRE

DENTAL HISTORY

Please circle YES or NO. If yes, please give details.

DENTAL HISTORY

Do you have a specific dental problem? Describe _____ YES NO

Do you have Dental exams on a routine basis? Last visit _____ YES NO

Do you think you have active decay or gum disease? _____ YES NO

Have you ever had a bad dental experience? Describe _____ YES NO

Who referred you to our office? _____

Name of previous dentist _____

MEDICAL HISTORY

Medical doctor's name _____

Are you under a doctors's care now? Why? _____ YES NO

Have you been hospitalized during the past two years? Why? _____ YES NO

Are you taking any medications, pills, or drugs? What? _____ YES NO

Please check if you are sensitive or allergic to any of the following:

- ☐ Penicillin
- ☐ Other Antibiotic _____
- ☐ Novocaine or Other Dental Anesthetic
- ☐ Nitrous Oxide
- ☐ Barbiturates (sleeping pills, sedatives)
- ☐ Sulfa Drugs
- ☐ Demerol
- ☐ Codeine
- ☐ Aspirin
- ☐ Foods
- ☐ Epinephrine
- ☐ Other _____

Please check if you have ever had any of the following:

- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Stroke
- ☐ Heart Murmur
- ☐ Rheumatic Fever/Scarlet Fever
- ☐ Mononucleosis
- ☐ Abnormal Blood Pressure (high or low)
- ☐ Severe or Frequent Headaches
- ☐ Fainting Spells/Convulsions
- ☐ Epilepsy
- ☐ Nervous Disorders or Psychiatric Care
- ☐ Ulcers
- ☐ Hepatitis, Liver Disease or Jaundice
- ☐ Artificial Transplants or Implants (Pacemaker, Heart Valve, Hip Joint)
- ☐ Eye Disease (Glaucoma, Cataracts)
- ☐ Ear Trouble
- ☐ Sinus Trouble
- ☐ Lung Disease (T.B., Asthma, Emphysema)
- ☐ Arthritis
- ☐ Kidney Disease or Infections
- ☐ Diabetes
- ☐ Blood Disorders (Anemia, Leukemia, Hemophilia)
- ☐ Blood Transfusion
- ☐ Herpes
- ☐ Venereal Disease
- ☐ Skin Disease _____
- ☐ X-ray, Radium or Cobalt Treatment
- ☐ Tumors, Malignancies, or Cancer
- ☐ (Are you) HIV Positive?

Is there any other information about your health which might be important for us to know? _____

WOMEN: Are you pregnant? YES NO Are you nursing? YES NO Are you taking Oral Contraceptives? YES NO

Delivery Date _____

Signature _____ Date _____

(Office Use Only)

COMMENTS AND UPDATE INFORMATION

Has this patient had any changes in health status since his/her last dental visit? Illness, allergies, hospitalization or daily medications?

Initial	Date	Comments	Signature