

HEALTH QUESTIONNAIRE

Name _____ Birth date _____

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Circle yes or no, whichever applies, in response to the following questions. Your answers are for our records only and will be considered confidential.

DENTAL

- Are you having any discomfort at this time Yes No
- Have you ever had any serious trouble associated with previous dental treatment? Yes No
If so explain? _____
- Does dental treatment make you nervous? No _____ Slightly _____ Moderately _____ Extremely _____
- Date of last dental visit _____
- Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? Yes No
If so when? _____
- How often do you brush _____
Brush is: Soft Medium Hard
- Do you have or have you ever had any of the following?

MOUTH

- | | | |
|---|-----|----|
| Bleeding, sore gums | Yes | No |
| Unpleasant taste/bad breath | Yes | No |
| Burning tongue/lips | Yes | No |
| Frequent blisters, lip/mouth | Yes | No |
| Swelling/lumps in mouth | Yes | No |
| Ortho treatments (braces) | Yes | No |
| Biting cheeks/lips | Yes | No |
| Clicking/popping jaw | Yes | No |
| Difficulty opening or closing jaw | Yes | No |

- Do you use the following?

- | | | |
|----------------------|-----|----|
| Brush | Yes | No |
| Dental floss | Yes | No |
| Fluoride rinse | Yes | No |
| Other | Yes | No |

TEETH

- | | | |
|---------------------------|-----|----|
| Loose teeth | Yes | No |
| Sensitive to hot | Yes | No |
| Sensitive to cold | Yes | No |
| Sensitive to sweets | Yes | No |
| Sensitive to biting | Yes | No |
| Food impaction | Yes | No |
| Clenching/grinding | Yes | No |
| If so, when _____ | | |
| Shifting in bite | Yes | No |
| Change in bite | Yes | No |

MEDICAL

- Has there been any change in your general health within the past year Yes No
- My last physical examination was on _____
- Are you now under the care of a physician Yes No
If so, what is the condition being treated _____
- The name and address of my physician is _____
- Have you had any serious illness within the past five (5) years Yes No
If so, what was the illness _____
- Have you been hospitalized or had an operation within the past five (5) years Yes No
If so, what was the problem _____
- Do you have or have you had any of the following diseases or problems
a. Rheumatic fever or rheumatic heart disease Yes No
b. Congenital heart disease Yes No
c. Cardiovascular disease (heart trouble, heart attack, heart murmur, coronary insufficiency, coronary occlusion, high/low blood pressure, arteriosclerosis, stroke, etc.) Yes No
1) Do you have pain in chest upon exertion Yes No
2) Are you ever short of breath after mild exercise Yes No
3) Do your ankles swell Yes No
4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep Yes No
d. Artificial or replacement valves Yes No
e. Pacemaker Yes No
f. Allergy Yes No
g. Sinus trouble Yes No
h. Asthma or hay fever Yes No
i. Hives or a skin rash Yes No
j. Fainting spells or seizures Yes No
k. Diabetes Yes No
1) Do you have to urinate (pass water) more than six times a day Yes No
2) Are you thirsty much of the time Yes No
3) Does your mouth frequently become dry Yes No

l. Hepatitis, jaundice or liver disease	Yes	No
m. Arthritis or inflammatory rheumatism	Yes	No
n. Artificial or replacement joints, prosthetic	Yes	No
o. Digestive system—Ulcers or stomach disorders (colitis).....	Yes	No
p. Kidney trouble	Yes	No
q. Tuberculosis	Yes	No
r. Persistent cough or cough up blood	Yes	No
s. Immune System disorders (including AIDS, HIV, ARC)	Yes	No
t. Venereal disease	Yes	No
u. Other		
8. Have you had abnormal bleeding associated with previous extractions, surgery or trauma?	Yes	No
a. Do you bruise easily	Yes	No
b. Have you ever required a blood transfusion	Yes	No
If so, explain the circumstances & when		
9. Have you ever tested positive for the AIDS virus?	Yes	No
10. Do you have any blood disorder such as anemia?	Yes	No
11. Have you had surgery or x-ray treatment for a tumor, growth, or other condition?	Yes	No
12. Are you taking any of the following:		
a. Antibiotics or sulfa drugs	Yes	No
b. Anticoagulants (blood thinners)	Yes	No
c. Medicine for high blood pressure	Yes	No
d. Cortisone (steroids)	Yes	No
e. Tranquilizers.....	Yes	No
f. Antihistamines	Yes	No
g. Aspirin	Yes	No
h. Insulin, tolbutamide (Orinase) or similar drug for diabetes	Yes	No
i. Digitalis or drugs for heart trouble	Yes	No
j. Nitroglycerin	Yes	No
k. Other medications	Yes	No
l. If "Yes" to any of the above, state drug name, dosage and frequency		
13. Are you allergic or have you reacted adversely to:		
a. Local anesthetics	Yes	No
b. Penicillin or other antibiotics	Yes	No
c. Sulfa drugs	Yes	No
d. Barbiturates, sedatives, or sleeping pills	Yes	No
e. Aspirin	Yes	No
f. Iodine	Yes	No
g. Codeine or other narcotics	Yes	No
h. Other		
14. Do you use any tobacco products	Yes	No
If so, how much per day and what		
15. Do you use any alcohol products	Yes	No
If so, how much per day/week/month and what		
16. Do you use any caffeinated products (coffee, tea, chocolate, etc.)	Yes	No
If so, how much per day and what		
17. Do you have any disease, condition, or problem not listed above that you think I should know about?	Yes	No
If so, explain		
18. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation	Yes	No
19. Are you wearing contact lenses	Yes	No
20. Are you experiencing stress or pressure in your work or at home	Yes	No
WOMEN		
20. Are you pregnant	Yes	No
21. Do you have PMS or problems associated with your menstrual period	Yes	No
22. Are you taking birth control or hormone therapy	Yes	No
Remarks:		

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 change in my medication, I will inform the dentist at the next appointment.

Signature of Patient

Date

Signature of Dentist

Date