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. Check yes or no, whichever applies, in response to the following questions. Your answers are for our records only and will be considered confidential.

DENTAL

YES NO

1 Are you having any discomfort at this time? ☐ ☐
2 Have you ever had any serious trouble associated with previous dental treatment? ☐ ☐
If so, explain ____________
3 Does dental treatment you nervous? No ☐ Slightly ☐ Moderately ☐ Extremely ☐
4 Date of last dental visit ____________
5 Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? ☐ ☐
If so, when? ____________
6 How often do you brush? ____________
Brush is: Soft ☐ Medium ☐ Hard ☐
7 Do you have or have you ever had any of the following? **(Check all that apply)**

Mouth

- Bleeding, Sore Gums ☐
- Unpleasant Taste/ Bad Breath ☐
- Burning Tongue/ Lips ☐
- Frequent Blisters, Lips/ Mouths ☐
- Swelling/ Lumps In Mouth ☐
- Ortho Treatments (Braces) ☐
- Biting Cheeks/ Lips ☐
- Click/ Popping Jaw ☐
- Difficulty Opening or Closing Jaw ☐

Teeth

- Loose Teeth ☐
- Sensitive To Hot ☐
- Sensitive To Cold ☐
- Sensitive To Sweets ☐
- Sensitive To Biting ☐
- Food Impaction ☐
- Clenching/ Grinding ☐
- If So, When ____________
- Shifting In Bite ☐
- Change In Bite ☐

8 Do you use the following?

- Brush ☐
- Dental Floss ☐
- Fluoride Rinse ☐
- Other ☐

MEDICAL

YES NO

1 Has there been a change in your general health within the past year ☐ ☐
2 My last physical exam was on ____________
3 Are you now under the care of a physician? ☐ ☐
If so, what is the condition being treated? ____________
4 The name and address of my physician is ____________

____
5 Have you had any serious illness within the past five (5) years? ☐ ☐
If so, what was the illness? ____________
6 Have you been hospitalized or had an operation within the past five (5) years? ☐ ☐
If so, what was the problem? ____________
7 Do you have or have you had any of the following diseases or problems?
a. Rheumatic Fever or Rheumatic Heart Disease ☐ ☐
b. Congenital Heart Disease ☐ ☐
c. Cardiovascular Disease (heart trouble, heart attack, heart murmur, coronary insufficiency coronary occlusion high/ low blood pressure, arteriosclerosis, stroke, etc.) ☐ ☐
Do you have pain in cheat upon exertion ☐ ☐
Are you ever short of breath when you lie down, require extra pillows when you sleep ☐ ☐
☐ ☐
d. Artificial or Replacement Valves ☐ ☐
e. Pacemaker ☐ ☐
f. Allergy ☐ ☐
g. Sinus Trouble ☐ ☐
h. Asthma or Hay Fever ☐ ☐
i. Hives or Skin Rash ☐ ☐

	YES	NO
j. Fainting Spells or Seizures	☐	☐
k. Diabetes	☐	☐
Do you have to urinate (pass water) more than six times a day	☐	☐
Are you thirsty much of the time	☐	☐
Does your mouth frequently become dry	☐	☐
l. Hepatitis, Jaundice or Liver Disease	☐	☐
m. Arthritis or Inflammatory Rheumatism	☐	☐
n. Artificial or Replacement Joints, Prosthetic	☐	☐
o. Digestive System: Ulcers or Stomach Disorders (Colitis)	☐	☐
p. Kidney Trouble	☐	☐
q. Tuberculosis	☐	☐
r. Persistent Cough or Cough Up Blood	☐	☐
s. Immune System Disorders (including AIDS, HIV, ARC)	☐	☐
t. Venereal Disease	☐	☐
u. Other	☐	☐
8 Have you had abnormal bleeding associated with previous extractions, surgery or trauma?	☐	☐
a. Do you bruise easily?	☐	☐
b. Have you ever required a blood transfusion? If so, explain the circumstance and when	☐	☐
9 Have you ever tested positive for the AIDS virus?	☐	☐
10 Do you have any blood disorder such as anemia?	☐	☐
11 Have you had surgery or x-ray treatment for a tumor, growth or other condition?	☐	☐

12 Are you taking any of the following:

- a. Antibiotics or Sulfa Drugs ☐
- b. Anticoagulants (blood thinners) ☐
- c. Medicine for High Blood Pressure ☐
- d. Cortisone (steroids) ☐
- e. Tranquilizers ☐
- f. Antihistamines ☐
- g. Aspirin ☐
- h. Insulin, Tolbutamide (Orinase) or similar drug for diabetes ☐
- i. Digitalis or Drugs for Heart Trouble ☐
- j. Nitroglycerin ☐
- k. Other Medications ☐
- l. If yes to any of the above, state drug name, dosage and frequency ______________________

13 Are you allergic or have reacted adversely to:

- a. Local Anesthetics ☐
- b. Penicillin or Other Antibiotics ☐
- c. Sulfa Drugs ☐
- d. Barbiturates, Sedatives or Sleeping Pills ☐
- e. Aspirin ☐
- f. Iodine ☐
- g. Codeine or Other Narcotics ☐
- h. Other ☐

	YES	NO
14 Do you use tobacco products? If so, how much per day and what ______________________	☐	☐
15 Do you use alcohol products? If so, how much per day/week/month and what ______________________	☐	☐
16 Do you use caffeinated products? (coffee, tea, chocolate, etc.) If so, how much per day and what ______________________	☐	☐
17 Do you have any disease, condition or problem not listed above I should know about? If so, explain ______________________	☐	☐
18 Are you employed in any situation which exposes you regularly to x-rays or ionizing radiation?	☐	☐
19 Are you wearing contact lenses?	☐	☐
20 Are you experiencing stress or pressure in your work or home?	☐	☐

WOMEN

	YES	NO
21 Are you pregnant?	☐	☐
22 Do you have PMS or problems associated with your menstrual period?	☐	☐
23 Are you taking birth control or hormone therapy?	☐	☐

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