

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

1. Are you having any discomfort at this time Yes No
2. Have you ever had any serious trouble associated with previous dental treatment Yes No
If so, explain _____
3. Does dental treatment make 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)? Yes No
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?

MOUTH

- | | | |
|---------------------------------------|-----|----|
| Bleeding, sore gums | Yes | No |
| Unpleasant taste/bad breath | Yes | No |
| Burning tongue/lips | Yes | No |
| Frequent blisters, lips/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 |

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 |

8. Do you use the following?
- Brush.....Yes No
- Dental floss
- Fluoride rinse
- Other.....Yes No

MEDICAL

1. Has there been any change in your general health within the past year Yes No
2. My last physical examination was on _____
3. Are you now under the care of a physician Yes No
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 Yes No
If so, what was the illness _____
6. Have you been hospitalized or had an operation within the past five (5) years Yes No
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 Yes No
 - b. Congenital heart disease
 - 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
 - 2) Are you ever short of breath after mild exercise
 - 3) Do your ankles swell
 - 4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep
 - d. Artificial or replacement valves
 - e. Pacemaker
 - f. Allergy

- 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 Yes No
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

