

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, 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

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 _____ Yes No
Fluoride rinse _____ Yes No
Other _____

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 _____ 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

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| 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

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|--|-----|----|
| 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:

- | | | |
|---|-----|----|
| 23. Have you ever taken any medicine for osteopenia or osteoporosis (bone density medicine)?..... | Yes | No |
| If so, when did you take it and for how long..... | | |

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