

HEALTH QUESTIONNAIRE

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care.

Please answer each question. Check the appropriate box and/or circle **Yes** or **No** where applicable. Example: Are you alive? **Yes** **No**

MEDICAL HISTORY

1. Are you in good health? **Yes** **No**
2. Date of last physical examination _____
3. Are you now under the care of a physician? **Yes** **No**
If so, what is the condition being treated? _____
4. Have you ever had any serious illness or operation? **Yes** **No**
If so, what illness or operation? _____
5. Have you ever been hospitalized? **Yes** **No**
If so, what was the problem? _____
6. Are you taking any medications, drugs or herbs? **Yes** **No**
If so, what? _____ What dosage? _____
7. Are you using any recreational drugs (marijuana, cocaine, etc.)? **Yes** **No** If so, what? _____
8. Have you ever been pre medicated with antibiotics for your dental treatment? **Yes** **No**
9. Are you sensitive or allergic to any drugs or materials? Penicillin; Tetracycline; Sulfa Drugs; Aspirin; Codeine; Latex; Other **Yes** **No**
If Other, what drugs? _____

10. Do you have or have you had any of the following: (Please circle 'Y' for Yes or 'N' for No - answer all conditions):

<input type="checkbox"/> Y <input type="checkbox"/> N Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma	<input type="checkbox"/> Y <input type="checkbox"/> N Sleep Apnea	<input type="checkbox"/> Y <input type="checkbox"/> N Angina Pectoris	<input type="checkbox"/> Y <input type="checkbox"/> N Pain in Jaw Joints	<input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric Treatment	<input type="checkbox"/> Y <input type="checkbox"/> N Other
<input type="checkbox"/> Y <input type="checkbox"/> N Herpes	<input type="checkbox"/> Y <input type="checkbox"/> N Tonsillitis	<input type="checkbox"/> Y <input type="checkbox"/> N Snoring	<input type="checkbox"/> Y <input type="checkbox"/> N Mental Disorder	<input type="checkbox"/> Y <input type="checkbox"/> N Artificial Prosthesis	<input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis or Jaundice	
<input type="checkbox"/> Y <input type="checkbox"/> N Stroke	<input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia	<input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur	<input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Disease	<input type="checkbox"/> Y <input type="checkbox"/> N Sickle Cell Disease	<input type="checkbox"/> Y <input type="checkbox"/> N Difficulty Swallowing	
<input type="checkbox"/> Y <input type="checkbox"/> N Ulcers	<input type="checkbox"/> Y <input type="checkbox"/> N Cold Sores	<input type="checkbox"/> Y <input type="checkbox"/> N Liver Disease	<input type="checkbox"/> Y <input type="checkbox"/> N Fainting Spells	<input type="checkbox"/> Y <input type="checkbox"/> N Cortisone Medicine	<input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Lesions	
<input type="checkbox"/> Y <input type="checkbox"/> N Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N Emphysema	<input type="checkbox"/> Y <input type="checkbox"/> N Blood Disease	<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic Fever	<input type="checkbox"/> Y <input type="checkbox"/> N Allergies to Metals	<input type="checkbox"/> Y <input type="checkbox"/> N Osteoporosis	
<input type="checkbox"/> Y <input type="checkbox"/> N Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatism	<input type="checkbox"/> Y <input type="checkbox"/> N Heart Ailments	<input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis (T.B.)	<input type="checkbox"/> Y <input type="checkbox"/> N Excessive Bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N X-Ray or Cobalt Treatment	
<input type="checkbox"/> Y <input type="checkbox"/> N Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N Chicken Pox	<input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack	<input type="checkbox"/> Y <input type="checkbox"/> N Blood Transfusion	<input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse	<input type="checkbox"/> Y <input type="checkbox"/> N Radiation Treatment of any kind	
<input type="checkbox"/> Y <input type="checkbox"/> N Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N Bruise Easily	<input type="checkbox"/> Y <input type="checkbox"/> N Cerebral Palsy	<input type="checkbox"/> Y <input type="checkbox"/> N Low Blood Sugar	<input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N Venereal Disease (Syphilis, Gonorrhea)	
<input type="checkbox"/> Y <input type="checkbox"/> N Seizures	<input type="checkbox"/> Y <input type="checkbox"/> N Head Injuries	<input type="checkbox"/> Y <input type="checkbox"/> N Drug Addiction	<input type="checkbox"/> Y <input type="checkbox"/> N Joint Replacement	<input type="checkbox"/> Y <input type="checkbox"/> N Low Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N Acquired Immune Deficiency Syndrome (AIDS)	
<input type="checkbox"/> Y <input type="checkbox"/> N Hay Fever	<input type="checkbox"/> Y <input type="checkbox"/> N Heart Failure	<input type="checkbox"/> Y <input type="checkbox"/> N Kidney Disease	<input type="checkbox"/> Y <input type="checkbox"/> N Nervous Disorders	<input type="checkbox"/> Y <input type="checkbox"/> N HIV Related Complex	<input type="checkbox"/> Y <input type="checkbox"/> N TMJ (Temporomandibular Joint) Disorder	
<input type="checkbox"/> Y <input type="checkbox"/> N Headaches	<input type="checkbox"/> Y <input type="checkbox"/> N Scarlet Fever	<input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy	<input type="checkbox"/> Y <input type="checkbox"/> N Tumors or Growths	<input type="checkbox"/> Y <input type="checkbox"/> N Respiratory Disease		
<input type="checkbox"/> Y <input type="checkbox"/> N Implant (s)	<input type="checkbox"/> Y <input type="checkbox"/> N Sinus Trouble	<input type="checkbox"/> Y <input type="checkbox"/> N Stomach Ulcers	<input type="checkbox"/> Y <input type="checkbox"/> N Allergies or Hives	<input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy or Seizures		

11. Do you have any disease, condition or problem not listed that you think we should know about? **Yes** **No**
If so, what? _____
12. Do you wear a cardiac pacemaker, or have you had heart surgery? **Yes** **No**
13. Do you smoke? If yes, how much? Cigarettes Cigars Packs per day **Yes** **No**
14. Have you ever taken the drugs Fen-Phen, Redux, Fosamax (Bisphosphonate), Zometa, Actonel, Boniva, Aredia, Diet Drugs? **Yes** **No**
15. (Women) Are you pregnant? If so how many months? **Yes** **No**
16. (Women) Do you have any problems associated with your menstrual period? **Yes** **No**
17. (Women) Do you take any birth control medication or hormones? **Yes** **No**

DENTAL HISTORY

1. Have you ever had a local anesthetic (Novocaine, etc.)? **Yes** **No**
2. Have you ever had any unfavorable reaction from a local anesthetic? **Yes** **No**
3. Have you had any serious trouble associated with any previous dental treatment? **Yes** **No**
If so, explain? _____
4. How long since your last full mouth X-Rays? _____ Weeks _____ Months _____ Years
5. How long since your last dental treatment? _____ Weeks _____ Months _____ Years
6. Does dental treatment make you nervous? Slightly Moderately Extremely? **Yes** **No**
7. Would you desire to be pre-sedated? **Yes** **No**

I hereby acknowledge I have received a copy of this practice's **NOTICE OF PRIVACY PRACTICES**. I further understand that the practice will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified, or changes in any way. Patient refused / was unable to sign because _____

I have received a copy of the **Dental Materials Fact Sheet** as required by law.

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 if my medications change, I will, without fail, inform the doctor at my next appointment.

A Date _____ Signature _____ Reviewed by _____ Lic. # _____ Date _____

B UPDATE — Since your last visit **A**:

1. Have you seen a medical doctor? **Yes** **No**
 2. Have you had a change in your medication? **Yes** **No**
 3. Have you had a change in your medical condition or had surgery? **Yes** **No**
- Please note changes in health since last visit. If no changes, please write "None"**

Date _____ Signature _____

C UPDATE — Since your last visit **B**:

1. Have you seen a medical doctor? **Yes** **No**
 2. Have you had a change in your medication? **Yes** **No**
 3. Have you had a change in your medical condition or had surgery? **Yes** **No**
- Please note changes in health since last visit. If no changes, please write "None"**

Date _____ Signature _____

REVIEWED BY	DO NOT WRITE IN THIS SPACE		
A	A	B	C
DATE _____	DATE _____	_____	_____
B	B.P. _____ / _____ / _____		
DATE _____	PULSE _____		
C	TEMP _____		
DATE _____	BY _____		

HEALTH QUESTIONNAIRE MUST BE CONTINUALLY UPDATED!

CONSENT FOR TREATMENT: I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

All services are rendered and accepted under the terms and conditions printed on the reverse hereof:

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

Signed: _____ Date: _____ Relationship to Patient _____