HEALTH QUESTIONNAIRE

NAME ____________________ DATE

REASON FOR SEEKING TREATMENT ____________________

1. Are you in good health?........YES NO
2. Has there been any change in your health within the past year?........YES NO
3. Date of last physical exam ____________
4. Are you now under medical care? ....YES NO
   If so, for what? ____________
5. Have you ever had a serious illness? ....YES NO
   If so, explain ____________
6. Do you have (or had) any of the following?
   - A. AIDS or ARC........YES NO
   - B. Hepatitis, jaundice, liver disease........YES NO
   - C. Tuberculosis........YES NO
   - D. Venereal disease (herpes, gonorrhea,etc..YES NO
   - E. Rheumatic fever/heart disease........YES NO
   - F. Congenital heart disease........YES NO
   - G. Any kind of heart disease........YES NO
     - Heart murmur, mitral valve prolapse......YES NO
   - H. Allergy or hay fever........YES NO
   - I. Asthma........YES NO
   - J. Hives or skin rash........YES NO
   - K. Fainting spells........YES NO
   - L. Diabetes........YES NO
   - M. Painful swollen joints........YES NO
   - N. Arthritis........YES NO
   - O. Stomach Ulcers........YES NO
   - P. Kidney trouble........YES NO
   - Q. Persistent cough/ cough up blood........YES NO
   - R. Epilepsy or seizures........YES NO
   - S. Artificial joints........YES NO
   - T. Addictions to alcohol or drugs........YES NO
7. Do you have chest pain on exertion?........YES NO
8. Are you short of breath after mild exercise...YES NO
9. Do your ankles swell?........YES NO
10. Do you get short of breath when you lie down, or require extra pillows to sleep?........YES NO
11. Do you bleed easily and/or a lot?........YES NO
12. Have you ever needed a blood transfusion..YES NO
13. Do you have anemia or blood problems?.....YES NO
14. Have you ever had cancer?........YES NO
15. Are you taking any of the following?
    - A. Antibiotics or sulfa drugs........YES NO
    - B. Blood thinners........YES NO
    - C. High blood pressure medicine........YES NO
    - D. Cortisone or steroids........YES NO
    - E. Aspirin or anti-inflammatory drugs........YES NO
    - F. Insulin, Orinase or similar drug........YES NO
    - G. Digitalis or heart drugs........YES NO
    - H. Nitroglycerin........YES NO
    - I. Narcotics........YES NO
    - J. Birth control pills........YES NO
    - K. Alcohol or antabuse........YES NO
    - L. Dilantin / anti-convulsants........YES NO
    - M. Recreational drugs........YES NO
    - N. List medications: ____________
16. Are you allergic to or react adversely to any of the following?
    - A. Local anesthetics (Novocain, etc.).YES NO
    - B. Penicillin........YES NO
    - C. Any antibiotics, which? ____________
    - D. Aspirin or anti-inflammatory........YES NO
    - E. Barbiturates, sedatives........YES NO
    - F. Sulfa drugs........YES NO
    - G. Iodine........YES NO
    - H. Codeine or other narcotics........YES NO
17. Have you had any serious trouble with prior dental work?........YES NO
    If so, explain ____________
18. Do you have any disease, condition, or other problem not listed that you think I should know about? If so, explain ____________
19. Date of last dental exam ____________
20. Have you ever been treated for any disease of the gums........YES NO
21. Do your gums bleed when you brush.YES NO
22. Do you clench or grind your teeth.....YES NO
23. Do you have frequent toothaches......YES NO
24. Do you get frequent mouth sores, such as cold sores or canker sores........YES NO
25. Have you had any injuries to your mouth or jaws........YES NO
    If so, explain ____________
26. Do you have any sores or swellings of your mouth or jaws........YES NO
27. Do you plan to keep your teeth........YES NO
28. Have you been satisfied with your previous dental care........YES NO
    If not, why? ____________
29. Are you employed in a job which exposes you to x-rays or radiation........YES NO
30. Do you wear contact lenses........YES NO

WOMEN ONLY-

31. Are you pregnant or think you might be? YES NO

PATIENT REGISTRATION

Date ____________

Patient's Name ________________________ Birthdate ______________
Marital status ____________ Sex M F Social Security # ____________________
Residence address ____________________ Home Phone # ____________________
____

Employed by __________________ Address ______________________________
Phone ____________ Years at current employment ______
Name of spouse ____________________
Spouse employed by ____________________ Spouse social security # __________

Whom may we thank for referring you?
____

Person responsible for paying account:
Name ______________________ Relation to patient ______________________
Address
____

Dental Insurance Information:
Insurance company name ____
Insurance company address ____
Group # ____________________________ Policy# ______________________
Insured's name ____________________ Relationship to patient ________________
Insured's birthday _____________ SS# ______________

Physician name ________________________
Address ______________________________
____
Telephone number ______________________
Whom may we contact in case of an emergency? ______________________________
Phone number ____________________
If you are filling out this form for another person, what is you relationship?
____

I understand that the information that I have given on both sides of this form is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I also authorize the dental staff to perform the necessary dental services that I may need.

Signature: ______________________________ *Date:* ______________

(over please!)