HEALTH QUESTIONNAIRE

To help ensure your well being while receiving treatment in our office, please answer the following questions.
All information will be considered confidential and for our records only. I certify the above information is correct to the best of knowledge.

Last name:________________________First name:______________________ Middle initial:_______DOB:________________

1. **Have you been examined and /or treated by a physician within the last year? YES NO ~ if yes, When? ________________**
   Physician's Name:____Physician's Phone:_____________________________
2. **Have you ever been seriously ill or hospitalized? YES NO *If yes When? ____**
3. **Do you require any antibiotic coverage before any dental treatment? YES NO**
4. **Are you on blood thinners? YES NO** ***if YES the medication you are taking*:____**

Please check (√) if you have ever had any of the following: *** Reviewed by:**

☐ Angina - Chest pain	☐ Infectious/communicable disease	**SENSITIVITIES/ALLERGIES:**
☐ Arthritis	☐ Inflammatory rheumatism	☐ Aspirin
☐ Artificial Joints (hip/knee)	☐ Lung/breathing problems	☐ Codeine
☐ Asthma	☐ Mitral Valve Prolapse	☐ Penicillin (Antibiotics)
☐ Blood pressure problems	☐ Nervous/mental problems	☐ Sulfa
(CIRCLE) TYPE: HIGH or LOW	☐ Transplants i.e.: Hip/Knee	☐ Tylenol
☐ Bruise easily	☐ Pacemaker/artificial valves	☐ Nitrous Oxide (anaesthetic gas)
☐ Cancer	☐ Prolong bleeding after injury	☐ Latex
☐ Radiation/ chemo treatment	☐ Persistent cough	
☐ Cold sores	☐ Painful swollen joints	Woman only:
☐ Congenital heart condition	☐ Rheumatic fever	Are you pregnant? Yes No
☐ Cortisone/steroid therapy	☐ Recent change in appetite	If so, how many ______ months
☐ Diabetes	☐ Severe headaches	
(CIRCLE) TYPE: Type 1 or Type 2	☐ Sinus trouble/ Sore throats	Do you smoke? YES NO
☐ Difficulty swallowing	☐ Stomach/intestinal problems	
☐ Earaches	☐ Tendency to faint	*** **Are you taking any medications?**
☐ Feel thirsty much of the time	☐ Trouble hearing	If so please list:
☐ Frequent indigestion/vomiting	☐ Tumors or growths	☐
☐ Heart Attack or Stroke ~ When?	☐ Venereal Disease	☐
☐ Heart murmur/ palpitations	Other not listed:	☐
☐ Liver disease/ Hepatitis Type:	☐	☐
☐ High risk group for AIDS/HIV	☐	☐

Is there anything else concerning your health not listed that you think the doctor should know about? YES NO

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1) When was your last dental visit? ____
2) Have you had regular dental exams in the past? If yes what was done: ____________________________
3) Have you had x-ray taken with in the last year? ____________________________________
4) Are you having dental discomfort or dental pain? ____________________________________
5) Have you ever experienced abnormal bleeding associated with previous extraction, surgery or trauma? YES NO
6) I brush ________________times a day. I floss ____________times a day.
7) Do your gums bleed when brush or floss? NEVER SOMETIMES OFTEN
8) Do you have any oral habits: clenching, grinding, nail biting, thumb sucking? YES NO
9) Have you ever had professional tooth brushing & flossing instructions? YES NO
10) I am interested in sedation. YES NO
11) Have you had and problems with or unpleasant reactions to dental treatment? YES NO
12) Are you happy with the appearance of your teeth? YES NO
13) My primary concerns is: ____
____

Date:______________________Signature:____

☐ Patient ☐ Parent ☐ Guardian

Updated on:	**Updated on:**	**Updated on:**
Pt's signature	**Pt's signature**	**Pt's signature**