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 premedicated with antibiotics for your dental treatment?	☐ Yes ☐ No
9. Are you sensitive or allergic to any drugs or materials? ☐Penicillin ☐Tetracyclin ☐ Sulfa Drugs ☐ Aspirin ☐ Codein ☐ Latex ☐ Other	☐ Yes ☐ No
If Other, what drugs?	

10. Do you or have you had any of the followings: (Please circle '**Y**' for Yes or '**N**' for No – Answer all conditions);

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

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 or any ☐ diet drugs?	☐ Yes ☐ No
15. (Women) Are you pregnant? If so, how many months?	☐ Yes ☐ No
16. (Women) Do you have any?? 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 ever 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 article'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 a 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 a 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 QUESTIONAIRE 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 Patient Information form.

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_____***