HEALTH QUESTIONNAIRE

Date: _____

Patient's Name: _____ Sex: ☐ M ☐ F Birthdate: _____

S.S. #: _____ Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced

Residence Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Work Phone:: _____

Employer: _____ Spouse S.S. #: _____

Name of Spouse: _____ Spouse Bus. Phone: _____

If Child, Parent's Name: _____ Referred By: _____

Who will pay this account? _____ Insured Birthdate: _____

Do you have Dental Insurance? ☐ Yes ☐ No Name of Company: _____

Name of Insured: _____

DENTAL

1. Have you ever had any serious trouble associated with previous dental treatment ..... Yes No
   If so, explain _____
2. Does dental treatment make you nervous? ☐ No ☐ Slightly ☐ Moderately ☐ Extremely
3. Date of last dental visit: _____
4. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? ..... Yes No
   If so, when? _____
5. Have teeth ever been treated with fluoride? ..... Yes No
6. Any injuries to teeth (falls, blows, etc.)? ..... Yes No
7. How often do you brush? _____ How often do you floss? _____
   Brush is: ☐ Soft ☐ Medium ☐ Hard
8. What concerns you most about your mouth? _____

MEDICAL

1. The name and address of my physician is _____
   _____
2. My last physical examination was on _____
3. Has there been any change in your general health within the past year? ..... Yes No
4. Are you now under the care of a physician? ..... Yes No
   If so, what is the condition being treated? _____
5. Have you had any serious illness or operation within in the past five (5) years? ..... Yes No
   If so, what was the illness? _____
6. Is your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
7. Have you ever had? (please check)

___ Anemia	___ Emphysema	___ Kidney Disease	___ Tuberculosis
___ Arthritis	___ Epilepsy	___ Liver Disease	___ Ulcers
___ Artificial Joints/Heart Valves	___ Glaucoma	___ Pacemaker	___ Venereal Disease
___ Asthma	___ Heart Trouble/Murmur	___ Rheumatic Fever	
___ Blood Disorders	___ Hepatitis	___ Sinus Trouble	
___ Diabetes	___ HIV, AIDS, ARC	___ Thyroid Problems	

Other (please explain) _____

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8. Have you had surgery or x-ray treatment for a tumor, growth, or other condition? ..... Yes No

9. Are you taking the following?

a. Antibiotics or sulfa drugs	Yes	No	f. Antihistamines	Yes	No
b. Anticoagulants (blood thinners)	Yes	No	g. Aspirin	Yes	No
c. Medicine for high blood pressure	Yes	No	h. Insulin, tolbutamide (Orinase) or similar drug for diabetes	Yes	No
d. Cortisone (steroids)	Yes	No	i. Digitalis or drugs for heart trouble	Yes	No
e. Tranquilizers	Yes	No	j. Nitroglycerin	Yes	No

10. Are you allergic or have you reacted adversely to?

a. Local anesthetics	Yes	No	e. Aspirin	Yes	No
b. Penicillin or other antibiotics	Yes	No	f. Iodine	Yes	No
c. Sulfa drugs	Yes	No	g. Codeine or other narcotics	Yes	No
d. Barbiturates, sedatives or sleeping pills	Yes	No	h. Other _____		

11. Do you have any disease, condition, or other problem not listed above that you think I should know about? ..... Yes No

If so, explain _____

_____

WOMEN

12. Are you pregnant? ..... Yes No

13. Are you taking birth control or hormone therapy? ..... Yes No

Remarks: _____

_____

_____

_____

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