

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 Yes No
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; 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):

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

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 _____