

HEALTH QUESTIONNAIRE

Name _____ Birth date _____

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Circle yes or no, whichever applies, in response to the following questions. Your answers are for our records only and will be considered confidential.

DENTAL

1. Are you having any discomfort at this time Yes No
2. Have you ever had any serious trouble associated with previous dental treatment? Yes No
If so explain? _____
3. Does dental treatment make you nervous? No Slightly Moderately Extremely
4. Date of last dental visit _____
5. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? Yes No
If so when? _____
6. How often do you brush _____
Brush is: Soft Medium Hard
7. Do you have or have you ever had any of the following?

MOUTH

- | | | |
|---|-----|----|
| Bleeding, sore gums | Yes | No |
| Unpleasant taste/bad breath | Yes | No |
| Burning tongue/lips | Yes | No |
| Frequent blisters, lip/mouth | Yes | No |
| Swelling/lumps in mouth | Yes | No |
| Ortho treatments (braces) | Yes | No |
| Biting cheeks/lips | Yes | No |
| Clicking/popping jaw | Yes | No |
| Difficulty opening or closing jaw | Yes | No |
8. Do you use the following?
Brush..... Yes No
Dental floss..... Yes No
Fluoride rinse..... Yes No
Other _____

TEETH

- | | | |
|---------------------------|-----|----|
| Loose teeth | Yes | No |
| Sensitive to hot | Yes | No |
| Sensitive to cold | Yes | No |
| Sensitive to sweets | Yes | No |
| Sensitive to biting | Yes | No |
| Food impaction | Yes | No |
| Clenching/grinding | Yes | No |
| If so, when _____ | | |
| Shifting in bite | Yes | No |
| Change in bite | Yes | No |

MEDICAL

1. Has there been any change in your general health within the past year Yes No
2. My last physical examination was on
3. Are you now under the care of a physician Yes No
If so, what is the condition being treated _____
4. The name and address of my physician is _____
5. Have you had any serious illness within the past five (5) years Yes No
If so, what was the illness _____
6. Have you been hospitalized or had an operation within the past five (5) years Yes No
If so, what was the problem _____
7. Do you have or have you had any of the following diseases or problems
a. Rheumatic fever or rheumatic heart disease Yes No
b. Congenital heart disease Yes No
c. Cardiovascular disease (heart trouble, heart attack, heart murmur, coronary insufficiency, coronary occlusion, high/low blood pressure, arteriosclerosis, stroke, etc.) Yes No
 1) Do you have pain in chest upon exertion Yes No
 2) Are you ever short of breath after mild exercise..... Yes No
 3) Do your ankles swell..... Yes No
 4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep Yes No
d. Artificial or replacement valves Yes No
e. Pacemaker..... Yes No
f. Allergy..... Yes No
g. Sinus trouble..... Yes No
h. Asthma or hay fever..... Yes No
i. Hives or a skin rash..... Yes No
j. Fainting spells or seizures Yes No
k. Diabetes..... Yes No
 1) Do you have to urinate (pass water) more than six times a day..... Yes No
 2) Are you thirsty much of the time..... Yes No
 3) Does your mouth frequently become dry..... Yes No

- l. Hepatitis, jaundice or liver disease Yes No
- m. Arthritis or inflammatory rheumatism.....Yes No
- n. Artificial or replacement joints, prostheticYes No
- o. Digestive system—Ulcers or stomach disorders (colitis)Yes No
- p. Kidney trouble.....Yes No
- q. TuberculosisYes No
- r. Persistent cough or cough up bloodYes No
- s. Immune System disorders (including AIDS, HIV, ARC)Yes No
- t. Venereal disease.....Yes No
- u. Other_____
- 8. Have you had abnormal bleeding associated with previous extractions, surgery or trauma'?Yes No
 - a. Do you bruise easily.....Yes No
 - b. Have you ever required a blood transfusionYes No
 - If so, explain the circumstances & when_____
- 9. Have you ever tested positive for the AIDS virus?Yes No
- 10. Do you have any blood disorder such as anemia'?Yes No
- 11. Have you had surgery or x-ray treatment for a tumor, growth, or other condition'?Yes No
- 12. Are you taking any of the following:
 - a. Antibiotics or sulfa drugsYes No
 - b. Anticoagulants (blood thinners)Yes No
 - c. Medicine for high blood pressureYes No
 - d. Cortisone (steroids).....Yes No
 - e. TranquilizersYes No
 - f. AntihistaminesYes No
 - g. Aspirin.....Yes No
 - h. Insulin, tolbutamide (Orinase) or similar drug for diabetesYes No
 - i. Digitalis or drugs for heart troubleYes No
 - j. Nitroglycerin.....Yes No
 - k. Other medicationsYes No
 - l. If "Yes" to any of the above, state drug name, dosage and frequency_____
- 13. Are you allergic or have you reacted adversely to:
 - a. Local anesthetics.....Yes No
 - b. Penicillin or other antibioticsYes No
 - c. Sulfa drugsYes No
 - d. Barbiturates, sedatives, or sleeping pillsYes No
 - e. Aspirin.....Yes No
 - f. IodineYes No
 - g. Codeine or other narcotics.....Yes No
 - h. Other_____
- 14. Do you use any tobacco productsYes No
- If so, how much per day and what_____
- 15. Do you use any alcohol productsYes No
- If so, how much per day/week/month and what_____
- 16. Do you use any caffeinated products (coffee, tea, chocolate, etc.)Yes No
- If so, how much per day and what_____
- 17. Do you have any disease, condition, or problem not listed above that you think I should know about'?Yes No
- If so, explain_____
- 18. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiationYes No
- 19. Are you wearing contact lensesYes No
- 20. Are you experiencing stress or pressure in your work or at homeYes No

WOMEN

- 20. Are you pregnantYes No
- 21. Do you have PMS or problems associated with your menstrual periodYes No
- 22. 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