HEALTH QUESTIONNAIRE

NAME _____ REGISTRATION NO. _____

Indicate your correct answer to each question by placing an "X" in either the "Yes", "No", or "Don't Know" column. Please answer all questions. Answers to the following questions are for our records only and will be considered confidential.

Name of your primary physician _____ Phone _____ May we request your health record? Yes ☐ No ☐

Physicians Address _____

	Yes	No	Don't Know
Have you been examined and/or treated by a physician within the last year?			
Are you taking medicines now?			
What? _____			
Have you been			
1 Seriously ill If yes, what? _____			
2. Hospitalized? If yes, what? _____			
3. Treated with X-ray, cobalt for tumors What area(s) _____			
4. Told you have a heart murmur			
Have you had			
5 Major Surgery If yes, what? _____			
6. Blood transfusion			
7. Rheumatic fever			
8. Inflammatory rheumatism			
9. Yellow jaundice			
10. Tuberculosis			
11. Venereal disease			
12. Heart attack			
13. Stroke			
14. Hives, skin rash			
15. Asthma, Hay fever			
16. Cancer			
17. Diabetes (Sugar disease)			
18. Injury to face or jaw			
18a Hepatitis			
Have you had unusual reaction to any of these medicines:			
19. Dental anesthesia			
20. Aspirin			
21. Penicillin			
22. Iodine			
23. Sleeping Pills			
24. Other: _____			
Hematology:			
Do you:			
25. Bleed a long time after an injury?			
26. Bruise easily?			
27. Have blood disorders, anemia, thin blood			
27.a Have you tested positive to the HIV virus?			
Head:			
Do you have:			
28. Severe headaches			
29. Eye troubles			
30. Frequent colds			
31. Sinus trouble			
32. Frequent nosebleeds			
33. Sore throats			
34. Sensitive teeth			
35. Aching teeth			
36. Bleeding gums			
37. Sore gums or mouth			
38. Frequent canker sores, fever blisters			
39. Sore jaw muscles			
40. Earaches			
41. Difficulty upon opening mouth wide			

Cardiorespiratory	Yes	No	Don't Know
Do you have:			
42. High blood pressure			
42.a A pacemaker			
43. Shortness of breath			
44. Chest pains			
45. Swollen ankles			
46. Persistent Cough			
47. Blood sputum produced by coughing			
Gastrointestinal:			
Have you had:			
48. Recent change of appetite			
49. Foods that you cannot eat			
50. Difficulty in swallowing			
51. Frequent indigestion			
52. Frequent vomiting			
52.a An ulcer			
Genitourinary:			
Do you:			
53. Feel thirsty much of the time			
54. Urinate more than six times a day			
55. Have kidney trouble			
Neuromuscular-Skeletal:			
Do you have:			
56. Painful, swollen joints			
57. Numb or prickling sensations on your skin			
58. A history of broken bones			
59. A tendency to faint			
60. Fits or convulsions			
Endocrine-Metabolic:			
Do you:			
61. Get tired easily			
62. Feel excessively nervous			
63. Feel more discomfort in hot weather than most other people			
Habits:			
Do you consistently use:			
64. Tobacco			
65. Alcoholic beverages			
66. Drugs:			
67. Other medicines:			
Women Only:			
Are:			
68. You now pregnant (How many months _____)			
69. You past menopause			
70. Your menstrual periods irregular			
Children Only:			
Is the child:			
71. A bed wetter			
72. Experiencing trouble in school			
73. A slow learner			
74. Has the child experienced an unfavorable reaction from medical or dental treatment			
75. Number of days missed from school last year			

Patient's Signature or, if a Minor, Signature of Parent or legal Guardian Date