HEALTH INFORMATION

Patient Name:_____ Approximate Date of Last Dental Visit:_____

Name of Medical Doctor:_____Phone # of Medical Doctor:_____

Have you ever had any of the following? Please answer all questions by marking YES or NO. If you are not sure, do not answer the question. Your response to this questionnaire will be held strictly confidential and will only be used to assist in the assessment of your medical conditions. If you have any hesitations, please discuss your concern with one of the staff members.

Cardiovascular

Yes No

- ☐ ☐ High Blood Pressure
- ☐ ☐ Congenital Heart Disease
- ☐ ☐ Rheumatic Fever
- ☐ ☐ Heart Murmur
- ☐ ☐ Heart Pacemaker
- ☐ ☐ Vascular Graft
- ☐ ☐ Heart or Bypass Surgery
- ☐ ☐ Artificial Heart Valve
- ☐ ☐ Congestive Heart Failure
- ☐ ☐ Awaken with breathing difficulty
- ☐ ☐ Angina Pectoris/Chest Pain
- ☐ ☐ Have you ever taken Prescription diet pills, Example: PhenFen?
- ☐ ☐ Swollen Ankles
- ☐ ☐ Irregular or rapid heart beat?
- ☐ ☐ Stroke/TIA
- ☐ ☐ Have you ever taken antibiotics before a dental appointment?
- ☐ ☐ Taken steroids/prednisone

Respiratory

Yes No

- ☐ ☐ Emphysema or Asthma
- ☐ ☐ Hay Fever/Seasonal Allergies
- ☐ ☐ Chronic cough or Bronchitis
- ☐ ☐ Cough up bloody sputum
- ☐ ☐ Tuberculosis (TB)
- ☐ ☐ Chronic Sinus Infections
- ☐ ☐ Shortness of Breath
- ☐ ☐ Do you use a CPAP?
- ☐ ☐ Do you use tobacco?
  - ☐ Cigarettes
  - ☐ Smokeless
  - ☐ Pipe
  - ☐ Other_____

How much?_____

For how long?_____

If you quit, how long ago?

_____

How much did you smoke?

_____

Females

Yes No

- ☐ ☐ Are you pregnant now?
  _____# of months
- ☐ ☐ Are you practicing birth control?
- ☐ ☐ Do you anticipate becoming pregnant?
- ☐ ☐ Are you breast feeding now?

Musculo-skeletal/CNS/Developmental

Yes No

- ☐ ☐ Frequent Headaches
- ☐ ☐ Fainting spells or loss of consciousness
- ☐ ☐ Seizures or Epilepsy
- ☐ ☐ Unexplained Visual Changes
- ☐ ☐ Artificial Joint
- ☐ ☐ Arthritis or Bone Disease
- ☐ ☐ Muscle Disease
- ☐ ☐ Spinal cord injury/paralysis
- ☐ ☐ Cerebral Palsy
- ☐ ☐ Autism
- ☐ ☐ Developmentally Challenged
- ☐ ☐ Alzheimer's/ Dementia
- ☐ ☐ Taking Bisphosphonates?
  Ex. Fosamax
- ☐ ☐ Taking/Taken Recreational Drugs, Example: Methamphetamines

Gastrointestinal/Genitourinary

Yes No

- ☐ ☐ Colitis or Ulcers
- ☐ ☐ Hepatitis or other liver disease
- ☐ ☐ Jaundice
- ☐ ☐ Renal Dialysis/transplant
- ☐ ☐ Kidney Disease
- ☐ ☐ Syphilis, gonorrhea or other Sexually Transmitted Disease
- ☐ ☐ Frequent heartburn or reflux
- ☐ ☐ Frequent canker sores
- ☐ ☐ Frequent cold sores
- ☐ ☐ Chronic diarrhea
- ☐ ☐ Frequent Vomitting

Hematologic/Endocrine/Immune

Yes No

- ☐ ☐ Blood Transfusion
- ☐ ☐ Denied permission to give blood
- ☐ ☐ Anemia/leukemia/lymphoma
- ☐ ☐ Hemophilia
- ☐ ☐ Sickle Cell Disease
- ☐ ☐ Blood clots or thrombosis
- ☐ ☐ Diabetes Type I / II
- ☐ ☐ Thyroid Disease
- ☐ ☐ Adrenal Gland Disease
- ☐ ☐ AIDS
- ☐ ☐ HIV Infection
- ☐ ☐ Bleeding or Bruising Tendency
- ☐ ☐ Sudden Weight Loss or Gain
- ☐ ☐ Frequent Thirst
- ☐ ☐ Frequent Hunger
- ☐ ☐ Frequent Urination
- ☐ ☐ Cancer/Radiation/Chemotherapy
- ☐ ☐ Systemic Lupus

Psychiatric

Yes No

- ☐ ☐ Nervousness
- ☐ ☐ Depression
- ☐ ☐ Anxiety
- ☐ ☐ Past/Present psychiatric care

Allergies

Yes No

- ☐ ☐ Penicillin/Sulfa Drugs
- ☐ ☐ Novocaine/Xylocaine and Other dental anesthetics
- ☐ ☐ Aspirin/Codeine
- ☐ ☐ Latex products
- ☐ ☐ Metals, including jewelry
- ☐ ☐ Other_____

Family History of Disease

Yes No

- ☐ ☐ Diabetes
- ☐ ☐ Heart Disease
- ☐ ☐ Tuberculosis(TB)
- ☐ ☐ Bleeding Disorders
- ☐ ☐ Smoking

Do you have any other conditions not already mentioned?_____

History of hospitalization/surgical procedures:_____

Current Medication: Please list the prescribed and/or over the counter medications you have taken within the last six months. Please include dosages and the condition requiring the medication.

MEDICATION	DOSAGE	CONDITION REQUIRING THIS MEDICATION	CLEARANCE
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Patient, Parent, or Guardian Signature:_____ **Date:**_____

OCCLUSAL SCREENING

YES	NO	
☐	☐	Do you clench or grind your teeth during the day?
☐	☐	Have you been made aware of clenching or grinding your teeth at night?
☐	☐	Do you have frequent headaches, neck or shoulder pain?
☐	☐	Are your jaws or teeth tired when you awaken?
☐	☐	Have you ever had pain in your jaw joint, the sides of your face or ears?
☐	☐	Have your jaws ever clicked or popped when you open your mouth?
☐	☐	Have you ever experienced difficulty moving your jaw or opening your mouth?
☐	☐	Do you chew on only one side of your mouth?

DENTAL HISTORY

YES	NO	
☐	☐	Are you having pain or discomfort related to your mouth?
☐	☐	Do you feel nervous about having dental treatment?
☐	☐	Have you ever had a bad experience in a dental office?
☐	☐	Have you ever had any complications following dental treatment?

If yes, please explain: _____

_____

Reason for your visit today: _____

Reviewed by Dr. _____ **Date:** _____