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
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):

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

B ***UPDATE — Since your last visit:***

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:***

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**

