HEALTH QUESTIONNAIRE

Please answer each question. 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 drugs or medicine? .... **Yes No**
   If so, what? ____________ What dosage? ____________
7. Are you sensitive or allergic to any drugs? ❑ Penicillin: ❑ Tetracycline: ❑ Sulfa Drugs: ❑ Other .... **Yes No**
   If other, what drugs? ____________
8. Do you have, or have you had any of the following: (Please check ✔ known conditions)?

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
❑	❑	Anemia	❑	❑	Rheumatic Fever	❑	❑	Rheumatism or Arthritis	❑	❑	Epilepsy
❑	❑	Heart Ailments	❑	❑	Blood Disease	❑	❑	Head Injuries	❑	❑	Mental Disorders
❑	❑	High Blood Pressure	❑	❑	Hepatitis, Jaundice or Liver Disease	❑	❑	Stomach Ulcers	❑	❑	Stroke
❑	❑	Low Blood Pressure	❑	❑	Kidney Disease	❑	❑	Venereal Disease	❑	❑	Glaucoma
❑	❑	Circulatory Problems	❑	❑	Tumors or Growths	❑	❑	Artificial Prosthesis (implants)	❑	❑	Aids/HIV
❑	❑	Respiratory Disease	❑	❑	Radiation Treatment of any kind	❑	❑	Herpes	❑	❑	Latex Allergy
❑	❑	Tuberculosis	❑	❑	Allergies	❑	❑	Acquired Immune Deficiency	❑	❑	Bisphosphonate-Boniva Actinol
❑	❑	Nervous Disorders	❑	❑	Asthma or Hay Fever	❑	❑	Difficulty in Swallowing	❑	❑	Osteoporosis
❑	❑	Diabetes	❑	❑	Fainting Spells or Seizures	❑	❑	Other ____________			
❑	❑	Excessive Bleeding	❑	❑	Sinus Trouble			____________			

9. Do you wear a cardiac pacemaker? .... **Yes No**
10. Have you had a joint replacement? .... **Yes No**
11. Have you had heart surgery? .... **Yes No**
12. Do you have any disease, condition or problem not listed that you think I should know about? .... **Yes No**
13. (Women) Are you pregnant? If so, how many months? .... **Yes No**
14. (Women) Do you have any problems associated with your menstrual period? .... **Yes No**

DENTAL HISTORY

1. Have you ever had a local anesthetic (Novacaine, 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? ____________
5. How long since your last Dental treatment? ____________
6. Does dental treatment make you nervous? .... **Yes No**
   If Yes, Check ✔ : ❑ Slightly ❑ Moderately ❑ Extremely
7. Would you desire to be pre-sedated? .... **Yes No**

Reviewed by Dentist ____________ **Date** ____________

Year 2
Change in Health ____________

Date ____________ **Signature** ____________

Year 3
Change in Health ____________

Date ____________ **Signature** ____________

Health Questionnaire MUST be updated every year!

#	Year 1	Year 2	Year 3
Date			
BP			
Pulse			
Temp			
By	/	/	/

DO NOT WRITE IN THIS SPACE