HEALTH QUESTIONNAIRE

The following information is strictly confidential. Please circle "Yes" or "No", whichever applies. If you have any questions please ask the receptionist for help.

1. Has there been any change in your general health within the past year? .... Yes No
   If so, please explain. ______
2. When was your last physical exam? ______
3. Are you now under the care of physician? .... Yes No
   If so, for what condition? ______
4. Have you ever had a serious illness or operation? .... Yes No
   If so, what was the problem? ______
5. Have you been hospitalized within the past five years? .... Yes No
   If so, what was the reason? ______
6. Do you need to be premedicated before dental treatment? .... Yes No
7. Do you use tobacco? .... Yes No
   What type? ______
8. Please circle any known allergies.

   Local Anesthetics
   Penicillin, Erythromycin, Tetracycline or other antibiotics
   Barbiturates, Sedatives or Sleeping Pills
   Ibuprofin (Advil, Motrin)
   Codeine or Other Narcotics
   Propoxyphene (Darvon)
   Aspirin
   Acetaminophen
   Nickel or Other Metals
   Latex
   Metallic Jewelry
   Other ______

9. Have you ever had or do you now have any of the following illnesses or conditions? .... Yes No

   Heart Attack
   Heart Disease
   Chest Pain (Angina)
   Congenital Heart Disease
   Heart Murmur
   Mitral Valve Prolapse
   Rheumatic Fever
   High Blood Pressure
   Stroke
   Bleeding Problems
   Stomach Ulcer
   Kidney Disease
   Liver Disease
   Hepatitis
   Thyroid Disease
   Arthritis
   Lung Disease
   Anemia
   Nasal Obstruction
   Sinus Trouble
   AIDS (HIV Positive)
   Psychiatric Treatment
   Tuberculosis
   Epilepsy
   Asthma
   Herpes
   Cancer
   Diabetes
   Glaucoma
   Swollen Ankles
   Alcohol or Substance Addiction
   Aneurysm
   Sleep Disorders
   Cirrhosis
   Yellow Jaundice
   Sickle Cell

10. Please circle any of the following medications/treatments you have experienced.

    Antibiotics
    Anticoagulants (Blood Thinners)
    High Blood Pressure Medication
    Steroids (Cortizone, Prednisone)
    Sedatives or Tranquilizers
    Birth Control Pills
    Antihistamines
    Aspirin
    Diabetic Medication
    Heart Medication
    Nitroglycerin
    Radiation Therapy
    Chemotherapy
    Other ______
    Joint Replacement
    Heart Bypass
    Vascular Grafts
    Blood Transfusion
    Phen Phen
    Heart Pacemaker or Defibrillator

11. Do you have any disease, condition, or problem not listed above that you think I should know about? .... Yes No
    If so explain. ______
12. (Females) Are you now pregnant? .... Yes No
13. Do you wear contact lens? .... Yes No
14. Do you now, or have you ever had painful or bleeding gums? .... Yes No
15. Do you now, or have you ever had painful or sensitive teeth? .... Yes No
16. Can you eat properly with your teeth in their present condition? .... Yes No
17. Do you have headaches frequently? .... Yes No
18. Are you satisfied with the present appearance of your teeth? .... Yes No
19. Do you have noise or pain in jaw joints (TMJ)? .... Yes No
20. What is the main reason you came to the office today? ______

The above information is complete and true to the best of my knowledge.

Remarks:

______ Signature of Patient (or responsible adult if minor) Date

______ Signature of Reviewer Date