Health Questionnaire

Name	M F	Date of Birth / /	Physician (Name)

Health problems that you may have or medication that you may be taking could have an important interrelationship with the care that you will be recieving. Thank you for answering the following questions. The information asked in this questionnaire is strictly CONFIDENTIAL.

1. Has there been any change in your general health in the past year? . . . . Yes No

2. Are you under the care of a physician? . . . . Yes No

If so, for what condition? ______________________ Date of Last Physician Exam ________

3. Are you taking any of the following medications? (circle) . . . . Yes No

Antibiotics, anticoagulants (blood thinners), blood pressure medication, cortisone, prednisone, steroids, tranquilizers, nerve pills, asprin, insulin, diabetic pills, nitroglycerin, heart medications, inderal (beta-blockers), digoxin, calcium channel blockers, ulcer medication, seizure medication, thyroid medication, antihistamines, or decongestants.

4. List the names of all medications you are currently taking: ______________________

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5. Are you allergic to or have a bad reaction to?: (circle) . . . . Yes No

penicillin, other antibiotics, local anesthetics (novocaine, xylocaine), codeine, asprin or ibuprofen, barbituates, sedatives, latex products, general anesthesia, soy, eggs, bisulfites, other: ______________________

8. Have you been hopitalized in the past five years? . . . . Yes No

If so, for what condition? ______________________

9. Do you have sleep apnea? . . . . Yes No

10. Do you or have you ever had:

(A) Bleed problems? (circle). . . . . Yes No

bleeding disorder, anemia, blood clotting disorder, blood transfusion, abnormal bleeding with previous extractions or surgery, bruise easily?

(B) A congenital heart defect or heart murmur, mitral valve prolapse?. . . . . Yes No

(C) Rheumatic fever or rheumatic heart disease?. . . . . Yes No

(D) Heart disease? (circle). . . . . Yes No

Heart attack, coronary artery disease, angina pectoris, congestive heart failure, previous heart surgery, stroke, palpitations, pacemaker, other: ______________________

(E) High blood pressure?. . . . . Low blood pressure?. . . . . Yes No

(F) Lung disease or breathing problems? (circle). . . . . Yes No

Asthma, emphysema, T.B., bronchitis, chronic lung disease, pneumonia, severe coughing, other: ______________________

(G) Diabetes, kidney disease, liver disease (hepatitis, jaundice)? (circle). . . . . Yes No

If so, explain: ______________________

(H) Any of the following problems? (circle). . . . . Yes No

Chest pain or exertion, shortness of breath with exertion, or with lying down, swelling of the ankles

(I) Any of the following problems? (circle). . . . . Yes No

Thyroid problems, stomach ulcers, seizures,epilepsy, nervous breakdown, psychiatric treatment, sinus or nasal problems, glaucoma, x-ray treatments for tumor, or chemotherapy?

11. Do you have implants placed anywhere in your body? (heart valve, hip, knee, other joint)? . . . . Yes No

12. Are you taking or have you taken Bisphosphonates (Fosamax, Actonel, Zometa, Aredia, Didronel, Boniva, Skelid, for osteoporosis, chemotherapy for cancer, multiple myeloma or other metastatic bone cancer, etc.)?
When? _________ Oncologist Name ______________________________ . . . . Yes No

13. Are you wearing contact lenses? . . . . Yes No

14. Do you smoke? How much? ___________________________ . . . . Yes No

15. Do you use alcohol? How much? ___________________________ . . . . Yes No

16. Have you been exposed to any communicable diseases or viruses or do you have any impairment of your immune system? . . . . Yes No

17. Do you abuse or have you abused alcohol or habit forming drugs? . . . . Yes No

18. Do you have or have you ever had jaw joint problems? (circle) . . . . Yes No
Clicking or popping of the jaw, pain near ear, difficulty opening mouth, jaw clenching, previous treatment for jaw problem?
If so, explain: ____

19. Do you have any other medical problems or condition not listed above? . . . . Yes No
Explain: ____

20. Are you on any weight loss or other special diets? . . . . Yes No

21. Have you taken the following:

Yes	No	Fen-Phen (Fenfluramine- Phentermine)
Yes	No	Pondimen (Fenfluramine)
Yes	No	Redux (dexfenfluramine)

If yes to any of the above, did you have a medical exam for heart issues? . . . . Yes No

<u>WOMEN:</u>

22. Are you pregnant, have a reason to suspect you maybe, or are you planning pregnancy? . . . . Yes No
Estimated delivery date: ______________________________

23. Are you nursing? . . . . Yes No

24. Are you taking birth control pills? . . . . Yes No

I certify that I have read and understand the above. I understand the importance of a truthful history to assist the doctor in providing the best care possible. I will not hold my dentist, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

______________________________ ______________ __________
Patient Signature Date Dr. initials
(Parents or legal guardian signature if patient is under 18 years of age)