Health Questionnaire

Medical History **Circle One**

1. Are you or have you recently been experiencing pain in your mouth or face? Yes No
2. Has there been any change in you general health during the last year? Yes No
3. Have you been examined by your physician within the last year? Yes No
4. Are you being treated by a physician for any condition now? Yes No
   If so what are you being treated for?_____
5. Are you taking any medications at this time? Yes No
   If so what are they?_____
6. Have you ever had a serious illness? Yes No
7. Have you ever been hospitalized or had an operation? Yes No
8. Has a physician or dentist ever told you that you had a tumor or cancer? Yes No
9. Have you ever had radiation or chemo treatments? Yes No
10. Have you ever had any of the following diseases or conditions? Please circle all that apply.

High Blood Pressure	Anemia	Jaundice	Kidney Disorder	Psychiatric Care	AIDS/HIV Positive
Low Blood Pressure	Stroke	Hepatitis	Bladder Disorder	Diabetes	Artificial Heart Valve
Shortness of Breath	Heart Attack	Ulcers	Venereal Disease	Liver Disease	Artificial Joint
Rheumatic Fever	Swollen Ankles	Asthma	Eye Disorders	Epilepsy	Osteoporosis
Rheumatic Heart Disease	Heart murmur	Tuberculosis	Glaucoma	Arthritis	Lung Disease
Chest Pain on Exertion	Bleeding Disorders	Epilepsy	Thyroid Disease	Rheumatism	Heart Trouble

11. Have you ever had excessive bleeding following extraction of teeth or a cut? Yes No
12. Do you have any allergies to any medicines? Penicillin? Asprin? Iodine? Codeine? Others? Yes No
    If yes please list allergies_____
13. Have you ever had a bad reaction to dental anesthetic or Novocain? Yes No
14. Have you ever had severe face, head or neck pain? Yes No
15. Do you consider yourself to be in good health? Yes No

FEMALES

16. Are you taking birth control medications of any type? Yes No
17. Are you pregnant or nursing? Yes No
18. Are you in or have you passed through menopause? Yes No

DENTAL

19. Are you satisfied with the appearance of your teeth? Yes No
20. Have you noticed any bad odors or tastes in your mouth? Yes No
21. Have you ever had periodontal or gum treatment? Yes No
22. Do your gums ever bleed? Yes No
23. Have you ever had orthodontics or braces? Yes No
24. Do you feel that your teeth are moving or drifting or your bite is different? Yes No
25. Do you have any difficulty chewing? Yes No
26. Do your teeth ever feel sore or hurt when you bite on them? Yes No
27. Do you grind or clench your teeth? Yes No
28. Do yours jaws click or pop when you open/close or chew? Yes No
29. Is there any other information you feel we should know about your health or teeth? Yes No
    If yes please elaborate_____

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health (or patients) health. It is my responsibility to inform the dental office of any changes in my health or medications, etc.

SIGNATURE OF PATIENT, PARENT OF GAURDIAN_____Date_____

Revisions:_____Patient Initials_____Date_____

Revisions:_____Patient Initials_____Date_____

Revisions:_____Patient Initials_____Date_____