HEALTH QUESTIONNAIRE

These questions are for your benefit to 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.

MEDICAL HISTORY-PATIENT NAME_____

Do you have a personal physician? ☐Yes ☐No

Physician's name_____ Ph.#_____

Your current physical health is: ☐Good ☐Fair ☐Poor

Are you currently under the care of a physician? ☐Yes ☐No

Please explain:_____

Are you taking any prescriptions, over the counter drugs or herbal supplements? ☐Yes ☐No

Please list:_____

Do you smoke or use tobacco in any form? ☐Yes ☐No

Are you now or have you ever taken **Fosamax** or any other **bisphosphonate**? ☐Yes ☐No

Do you have any metal rods, pins or implants? ☐Yes ☐No

Do you require antibiotics before dental treatment? ☐Yes ☐No

Women: Are you using a prescribed method of birth control? ☐Yes ☐No

Are you pregnant? ☐Yes ☐No Week#_____

Are you nursing? ☐Yes ☐No

Have you ever had any of the following diseases or medical problems? Please check yes or no to conditions below.

Y	N		Y	N		Y	N		Y	N	
☐	☐	Abnormal Bleeding	☐	☐	Difficulty Breathing	☐	☐	Hepatitis	☐	☐	Psychiatric Problems
☐	☐	Anemia	☐	☐	Emphysema	☐	☐	Herpes/blisters	☐	☐	Radiation treatment
☐	☐	Arthritis	☐	☐	Fainting/Seizures	☐	☐	High/Low Blood Pressure	☐	☐	Rheumatic Fever
☐	☐	Artificial bones/joints/valves	☐	☐	Frequent Headaches	☐	☐	HIV+/AIDS	☐	☐	Shingles
☐	☐	Asthma	☐	☐	Glaucoma	☐	☐	Hospitalized for any reason	☐	☐	Sickle Cell/Traits
☐	☐	Blood Transfusion	☐	☐	Hay Fever	☐	☐	Kidney Problems	☐	☐	Sinus Problems
☐	☐	Cancer/Chemotherapy	☐	☐	Heart Attack/Stroke	☐	☐	Liver Disease	☐	☐	Thyroid Problems
☐	☐	Chemical Dependency	☐	☐	Heart Murmur	☐	☐	Lupus	☐	☐	Tuberculosis/TB
☐	☐	Congenital Heart Defect	☐	☐	Heart Surgery/Pacemaker	☐	☐	Mitral Valve Prolapse	☐	☐	Ulcers/Colitis
☐	☐	Diabetes	☐	☐	Hemophilia	☐	☐	Osteoporosis/Paget's	☐	☐	Venereal Disease

Please list any serious medical condition(s) that you have ever had:_____

_____

Are you **ALLERGIC** or **SENSITIVE** to any of the following?

☐Yes ☐No **Aspirin** ☐Yes ☐No **Dental Anesthetics** ☐Yes ☐No **Penicillin**

☐Yes ☐No **Codeine** ☐Yes ☐No **Erythromycin** ☐Yes ☐No **Metals/Plastics**

☐Yes ☐No **Latex** ☐Yes ☐No **Tetracycline**

List any other drug/material allergies:_____

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 medication changes, I will without fail inform the doctor at my next appointment.

Date:_____ Signature (Parent/Guardian if minor)_____

Health reviewed by:_____ Date:_____

Office use only-Update medical history on other side.