HEALTH QUESTIONNAIRE [redacted]

Name _____ Birthdate _____

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Circle yes or no, whichever applies, in response to the following questions. Your answers are for our records only and will be considered confidential.

DENTAL

1. Are you having any discomfort at this time..... Yes No
2. Have you ever had any serious trouble associated with previous dental treatment?..... Yes No
   If so, explain _____
3. Does dental treatment make you nervous? No ____ Slightly ____ Moderately ____ Extremely ____
4. Date of last dental visit _____
5. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)?..... Yes No
   If so, when? _____
6. How often do you brush _____
   Brush is: Soft ☐ Medium ☐ Hard ☐
7. DO YOU WEAR DENTURES?..... Yes No
8. Do you have or have you ever had any of the following?

MOUTH

Bleeding, sore gums.....	Yes	No
Unpleasant taste/bad breath.....	Yes	No
Burning tongue/lips.....	Yes	No
Frequent blisters, lips/mouth.....	Yes	No
Swelling/lumps in mouth.....	Yes	No
Ortho treatments (braces).....	Yes	No
Biting cheeks/lips.....	Yes	No
Clicking/popping jaw.....	Yes	No
Difficulty opening or closing jaw.....	Yes	No

TEETH

Loose teeth.....	Yes	No
Sensitive to hot.....	Yes	No
Sensitive to cold.....	Yes	No
Sensitive to sweets.....	Yes	No
Sensitive to biting.....	Yes	No
Food impaction.....	Yes	No
Clenching/grinding.....	Yes	No
If so, when _____		
Shifting in bite.....	Yes	No
Change in bite.....	Yes	No

MEDICAL

1. Has there been any change in your general health within the past year..... Yes No
2. My last physical examination was on _____
3. Are you now under the care of a physician..... Yes No
   If so, what is the condition being treated _____
4. The name and address of my physician is _____

   _____
5. Have you had any serious illness within the past five (5) years..... Yes No
   If so, what was the illness _____
6. Have you been hospitalized or had an operation within the past five (5) years..... Yes No
   If so, what was the problem _____
7. Do you have or have you had any of the following diseases or problems
   a. Rheumatic fever or rheumatic heart disease..... Yes No
   b. Congenital heart disease..... Yes No
   c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high/low blood pressure, arteriosclerosis, stroke, etc.)..... Yes No
   d. Artifical or replacement valves..... Yes No
   e. Pacemaker..... Yes No
   f. Sinus trouble..... Yes No
   g. Diabetes..... Yes No
   h. Hepatitis, jaundice or liver disease..... Yes No
   i. Arthritis or inflammatory rheumatism..... Yes No
   j. Kidney trouble..... Yes No
   k. Tuberculosis..... Yes No
   l. Immune System disorders (including AIDS, HIV, ARC)..... Yes No
   m. Venereal disease..... Yes No
   n. Other _____

8. Have you had abnormal bleeding associated with previous extractions, surgery or trauma..... Yes No
   a. Have you ever required a blood transfusion..... Yes No
   If so, explain the circumstances & when _____
9. Have you ever tested positive for the AIDS virus..... Yes No
10. Do you have any blood disorder such as anemia..... Yes No
11. Are you taking any of the following:
   a. Antibiotics or sulfa drugs..... Yes No
   b. Anticoagulants (blood thinners)..... Yes No
   c. Medicine for high blood pressure..... Yes No
   d. Cortisone (steroids)..... Yes No
   e. Tranquilizers..... Yes No
   f. Antihistamines..... Yes No
   g. Aspirin..... Yes No
   h. Insulin, tolbutamide (Orinase) or similar drugs for diabetes..... Yes No
   i. Digitalis or drugs for heart trouble..... Yes No
   j. Nitroglycerin..... Yes No
   k. Other medications _____
   l. If "Yes" to any of the above, state drug name, dosage and frequency _____
12. Are you allergic to latex gloves..... Yes No
13. Are you allergic or have you reacted adversely to:
   a. Local anesthetics..... Yes No
   b. Penicillin or other antibiotics..... Yes No
   c. Sulfa drugs..... Yes No
   d. Barbiturates, sedatives, or sleeping pills..... Yes No
   e. Aspirin..... Yes No
   f. Iodine..... Yes No
   g. Codeine or other narcotics..... Yes No
   h. Other _____
14. Do you use any tobacco products..... Yes No
   If so, how much per day and what _____
15. Do you have any disease, condition, or problem not listed above that you think I should know about.... Yes No
   If so, explain _____

WOMEN

16. Are you pregnant..... Yes No

Remarks:

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 change in my medication, I will inform the dentist at the next appointment.

_____ _____

Signature of Patient Date Signature of Dentist Date