Health Questionnaire Date_____

Name_____ Preferred Phone (_____)_____

Height _____ Weight _____ Male Female Date of Birth _____-_____-_____

Whom may we contact in case an emergency? _____Phone (_____)_____

Name & Relationship

Physicians Name _____ Phone (_____)_____

For the following questions please circle YES or NO, whichever applies. Your answers are for our records only and will be considered confidential. Please note that you may be asked some questions about your responses to this questionnaire ad there may be additional questions concerning your health.

NO	**YES**	Has there been any change in your general health within the past year?

Date of last physical _____

NO	**YES**	Are you under the care of a physician? If so what for?
NO	**YES**	Have you had any serious illness, or been hospitalized in the past 5 years?

If so, for what reason? _____

Do you have or have you had any of the following problems or diseases?

NO	**YES**	Cardiovascular disease? (heart attack, angina, coronary insufficiency, coronary occlusion, arteriosclerosis, stroke or any heart surgery) **Please circle*
NO	**YES**	Heart murmur, rheumatic heart disease, mitral valve prolapsed, congenital heart defects or artificial heart valves/stents? **Please circle*
NO	**YES**	Do you have a cardiac pacemaker?
NO	**YES**	Any other cardiac conditions?

NO	**YES**	Seasonal Allergies?
NO	**YES**	Sinus Issues?
NO	**YES**	Bronchitis?
NO	**YES**	Respiratory problems?

NO	**YES**	Have you ever had any treatment for cancer?
NO	**YES**	Have you ever had any treatment for tumors or growths? If so please list:

NO	**YES**	Have you ever or do you currently take Bisphosphonate drugs or other Osteoporosis drugs or treatments?

NO	**YES**	Stomach Ulcer?
NO	**YES**	Acid Reflux?
NO	**YES**	Hyperacidity?

NO	**YES**	High blood pressure?
NO	**YES**	Low blood pressure?
NO	**YES**	Controlled blood pressure with medication?

NO	**YES**	Have you had abnormal bleeding?
NO	**YES**	Have you ever required a blood transfusion?
NO	**YES**	Do you have a blood disorder such as anemia?

NO	**YES**	Do you use tobacco products? Circle - *Cigarettes Cigars Chewing tobacco How much: _____/per day*
NO	**YES**	Have you ever had alcohol or substance abuse issues?

NO	**YES**	Do you have chest pain upon exertion?
NO	**YES**	Are you ever short of breath after mild exercise or when lying down?
NO	**YES**	Fainting spells?

NO	**YES**	Thyroid problems?
NO	**YES**	Persistent swollen glands in neck?

NO	**YES**	Persistent cough or cough producing blood?
NO	**YES**	Asthma?
NO	**YES**	Emphysema?

NO	**YES**	Jaundice?
NO	**YES**	Hepatitis?
NO	**YES**	Liver disease?

NO	**YES**	Do your ankles swell?
NO	**YES**	Painful swollen joints?
NO	**YES**	Arthritis?
NO	**YES**	Joint replacement hip, knee or other? * Please specify

NO	**YES**	Kidney trouble?
NO	**YES**	Diabetes?

NO	**YES**	AIDS or HIV or STD?
NO	**YES**	Tuberculosis?

NO	**YES**	Recent weight loss?
NO	**YES**	Persistent diarrhea?

NO	**YES**	Epilepsy?
NO	**YES**	Neurological disorder? Please specify - _____

NO	**YES**	Problems with your immune system?
NO	**YES**	Problems with mental health?

NO	**YES**	Do you snore?
NO	**YES**	Do you have trouble sleeping through the night?
NO	**YES**	Do you have a history of sleep apnea?
NO	**YES**	Are you supposed to wear a CPAP?
NO	**YES**	Do you wear your CPAP as instructed?

NO	**YES**	Do you have any other disease, condition, or problem not listed? If so explain:
NO	**YES**	**Are you currently taking any medications including non-prescription drugs? If so please list them below.**

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Are you allergic or have you had a reaction to:

NO	**YES**	Dental anesthetics	**NO**	**YES**	Sleeping Pills
NO	**YES**	Penicillin	**NO**	**YES**	Barbiturates
NO	**YES**	Erythromycin	**NO**	**YES**	Sedatives
NO	**YES**	Tetracycline	**NO**	**YES**	Sulfa Drugs
NO	**YES**	Any other antibiotics	**NO**	**YES**	Iodine
NO	**YES**	Aspirin	**NO**	**YES**	Jewelry
NO	**YES**	Codeine	**NO**	**YES**	Latex
NO	**YES**	Other narcotics	**NO**	**YES**	Other * Please specify:_____

WOMEN

NO	**YES**	Are you pregnant? If so how many weeks? _____
NO	**YES**	Are you nursing?
NO	**YES**	Do you take birth control? If so which kind? _____

NEW PATIENTS

NO	**YES**	Are you currently in any pain?
NO	**YES**	Do you require antibiotics before any dental treatment?
NO	**YES**	Do you floss daily?
NO	**YES**	Do you gums ever bleed?
NO	**YES**	Have you ever had any gum treatment?
NO	**YES**	Have you ever been treated for periodontal disease?
NO	**YES**	Do you currently or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)?
NO	**YES**	Are your teeth sensitive to heat, cold or other?_____
NO	**YES**	Are you happy with the way your smile looks?
NO	**YES**	Have your ever had a serious/difficult problem associated with any previous dental work? If so please explain below:

_____

Your current dental health is: _____ GOOD _____FAIR _____POOR

I certify that I have read and understood the above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold my dentist or any member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____
Patient signature/Parent or Guardian of patient's under the age of 18

OFFICE USE ONLY

I verbally reviewed the medical/dental information with the patient named herein.

_____ _____
Signature of Dentist Date

MEDICAL HISTORY UPDATE

Date	Comments	Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____