HEALTH QUESTIONNAIRE

Please answer the following questions to the best of your ability, realizing that true and accurate answers are important to the delivery of quality care. <u>All information you provide will be kept confidential.</u>

►PLEASE ANSWER BY CIRCLING Yes (Y) or No (N) FOR EACH INDIVIDUAL QUESTION◄

1. Y N Are you in good health ?
2. Y N Has there been any change in your general health in the past year ?
   Approximate date of your last check-up by physician:______________________________
3. Y N Are you currently under a physician's care ?
   If so, for what? ____________________________________
   Treating Physician's Name: ________________________ Phone Number: ____________
4. Y N Do you have or ever had any of the following: **(Please check all that apply)**
   Heart disease detected at birth? Stomach ulcers? Diabetes?
   Lung disease? (asthma, emphysema, bronchitis, TB, pneumonia, shortness of breath, severe cough)
   Cardiovascular disease? (chest pain, heart trouble, heart attack, coronary disease, high blood pressure, heart surgery, angioplasty, pacemaker)
   Neurologic disorders? (epilepsy , seizures, fainting, dizziness, nervous disorders)
   Blood Disease? (bleeding disorders, anemia, blood transfusion)
   Rheumatic Fever? Psychological Problems? Kidney Disease?
   Liver Disease? (jaundice, hepatitis)
5. Y N Do you bruise easily?
6. Y N Do you have frequent or recurring mouth sores?
7. Y N Do you have implants or artificial joints anywhere in your body? (heart valve, hip, knee)
8. Y N Have you had any radiation (X-Ray treatment for cancer) in head and neck region?
9. Y N Any sinus or nasal problems?
10. Y N Any disease, drug or transplant operation that has depressed your inmune system?
11. Y N Recurrent infections of any kind?
12. Y N Are you taking any of the following: **(Please check all that apply)**
    Antibiotics? Anticoagulants? (blood thinners) Thyroid medications?
    Steroids? Descongestant, antihistamines? High blood pressure medications?
    Tranquilizers, antidepressants? Aspirin? Narcotics, opioids, or other pain relievers?
    Weight reduction pills? Over the counter or "natural" products?
    Marijuana, cocaine or any other "recreational" drugs?
13. List all current medications here: ____________________________________
    ____
    ____
14. Y N Are you allergic to or had a bad reaction from any of these: **(Please check all that apply)**
    Local anesthetic? Penicillin, Amoxicillin? Other antibiotics? ____________
    Aspirin, ibuprophen, or any other pain medicines? Codein or other narcotics?
    Latex? Other allergic reactions: ________________________
15. Y N Have you ever had a complete series of x-rays taken of your teeth ? If so, when was the last time? ________
16. Y N Have you ever had noises or pain in your jaw joint?
17. Y N Do you generally tolerate dental treatment well?
18. Y N Do you have any other disease, condition or problem not listed above that you think the doctor should know?
19. Y N Do you wish to talk to the doctor privately about anything?
20. What is the main reason for your visit? ______________________________

For women:

21. Y N Are you pregnant or think you are?
22. Y N Are you taking birth control pills?
23. Y N Are you breast feeding?

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is correct.

Patient __________________________________ Date: ______________
Parent Signature of person completing Health Questionnaire
Guardian

____
Print your name Doctor's Initials