Health Questionnaire

These questions are for your benefit and 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.

I- MEDICAL HISTORY:

1- Are you in good health? **Yes** **No**

2- Date of last physical examination _____

3- Are you now under the care of a physician? **Yes** **No**

If so what is the condition being treated? _____

4- Have you ever had any serious illness or operation? **Yes** **No**

If so, what illness or operation? _____

5- Have you ever been hospitalized? **Yes** **No**

If so, what was the problem? _____

6- Are you taking any medicine, or herbal supplements? ❑ **Yes** ❑ **No** or any recreational drugs? **Yes** **No**

If so, what? _____

7- Have you before, or are you now taking any medications for bone density? **Yes** **No**

8- Have you ever been pre-medicated with antibiotics prior to your dental treatment? **Yes** **No**

9- Are you sensitive or allergic to any drugs? ❑ **Penicillin;** ❑ **Tetracycline;** ❑ **Sulfa;** ❑ **Aspirin;** ❑ **Codeine** **Yes** **No**

If other, what drugs? _____

10- Are you taking, or are scheduled to take antiresorptive agent (like Fosamax, Actonel, Atelvia, Boniva, Reclast, Prolia)? **Yes** **No**

11- Since 2001, were you treated, or are you scheduled to take an antiresorptive agent (like Aredia, Zometa, XGEVA)? **Yes** **No**

12- Do you have or have you had any of the following: (Please Check ✓ any known conditions):

Yes	No		Yes	No		Yes	No		Yes	No		Yes	No	
❑	❑	Anemia	❑	❑	Cold Sores	❑	❑	High Blood Pressure	❑	❑	Pain in Jaw Joints	❑	❑	Tumors or Growths
❑	❑	Hemophilia	❑	❑	Ulcers	❑	❑	Low Blood Pressure	❑	❑	Joint Replacement	❑	❑	Chemotherapy
❑	❑	Stroke	❑	❑	Sinus Trouble	❑	❑	Heart Murmur	❑	❑	Respiratory Problems	❑	❑	Radiotherapy
❑	❑	Blood Disease	❑	❑	Tonsillitis	❑	❑	Mitral Valve Prolapse	❑	❑	Angina Pectoris	❑	❑	Cortisone Medicine
❑	❑	Transfusion	❑	❑	Herpes	❑	❑	Pace Maker	❑	❑	Thyroid Disease	❑	❑	Kidney Disease
❑	❑	Bruise Easily	❑	❑	Arthritis	❑	❑	Phen Fen Diet Pills	❑	❑	Epilepsy or Seizures	❑	❑	Drug Addiction
❑	❑	Asthma	❑	❑	Diabetes	❑	❑	Rheumatic Fever	❑	❑	Nervous Disorder	❑	❑	Allergy to Latex
❑	❑	Hay Fever	❑	❑	Scarlet Fever	❑	❑	Artificial Prosthesis	❑	❑	Psychiatric Treatment	❑	❑	Hepatitis or Jaundice
❑	❑	Heart Attack	❑	❑	Tuberculosis	❑	❑	Congenital Heart Lesions	❑	❑	HIV Positive	❑	❑	A.I.D.S.

13- Do you have any disease, condition or problem not listed that you think we should know about? **Yes** **No**

If so, what is it? _____

14- Do you smoke? If so, how much per day? **Yes** **No**

15- **Women:** Are you pregnant? If so how many months? **Yes** **No**

Do you take Birth Control Pills? **Yes** **No**

II- DENTAL HISTORY:

1- Do your gums ever bleed when brushing or flossing? **Yes** **No**

2- Are your teeth sensitive to Hot / Cold / Sweets / Biting? **Yes** **No**

3- Do you have an unpleasant taste / Bad Breath? **Yes** **No**

4- Have you ever had local anesthetic (Lidocaine, Carbocaine, etc.)? **Yes** **No**

5- Have you ever had any unfavorable reaction from a local anesthetic? **Yes** **No**

6- Have you had any serious trouble with any previous dental treatment? **Yes** **No**

If so, what? _____

7- Does dental treatment make you nervous? ❑ Slightly; ❑ Moderately; ❑ Extremely; **Yes** **No**

8- How long since your last dental treatment? _____

9- Have you had any periodontal treatment? **Yes** **No**

11- Are you happy with your smile? **Yes** **No**

12- If there was an easy and fast way to whiten your teeth, would you want it? **Yes** **No**

To the best of my knowledge, all of the preceding information is correct and true. If I have any changes in my health or medications, I will promptly inform the doctor at my following appointment.

Date _____ **Signature** _____ **BP** _____ **Pulse** _____