HEALTH HISTORY QUESTIONNAIRE

It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

NAME (Last, First, MI.) _____ Birthdate _____

Social Security # _____

PERSONAL HEALTH HISTORY

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

Do you drink excessively
Yes ☐ No ☐

Have you ever taken Fosamax, Actonel, Boniva or any other bisphosphonate? Yes ☐ No ☐

Have you ever taken any dietary supplements such as Fen-Phen/Redux? Yes ☐ No ☐

ARE YOU **ALLERGIC TO OR HAVE REACTED ADVERSELY** TO ANY OF THE FOLLOWING MEDICATIONS? (CIRCLE) YES ☐ NO ☐

Aspirin Local Anesthetic Erythromycin
Penicillin Codeine Latex

Are you aware of being allergic to any other medications Or substances? if yes, please list:_____ YES ☐ NO ☐

For Women:
Are you pregnant? YES ☐ NO ☐
Are you nursing? YES ☐ NO ☐
Are you using any type of birth control? YES ☐ NO ☐

DENTAL HISTORY

	YES	NO
HOW LONG SINCE you have seen a dentist _____		
Last COMPLETE Dental Exam, Date _____		
Are you having PROBLEMS now?	☐	☐
WHAT? _____		
Are you currently in PAIN?	☐	☐
Do you wear DENTURES? (Partials or Full)	☐	☐
Are you APPREHENSIVE about dental treatment?	☐	☐
Do your gums BLEED, SORE, SWOLLEN or TENDER or IRRITATED	☐	☐
Are your teeth SENSITIVE To hot, cold, sweets, pressure? (circle)	☐	☐
Are your teeth loose?	☐	☐
Are you UNHAPPY with the APPEARANCE of your teeth?	☐	☐
Are you aware of GRINDING or CLENCHING your teeth?	☐	☐
Have you worn BRACES on your teeth (ORTHODONTICS)	☐	☐
Do you have DISCOLORED teeth that bother you?	☐	☐
Would you like your smile to LOOK BETTER or DIFFERENT?	☐	☐
Do you REGULARLY use DENTAL FLOSS?	☐	☐

MEDICAL HISTORY

	YES	NO
Do you have CURRENT HEALTH PROBLEMS?	☐	☐
Are you under PHYSICIAN'S CARE now?	☐	☐
For WHAT? _____		
Have you had surgery?	☐	☐
If so, Please Specify _____		
Do you have numbness or pain in the FACE/NECK/MOUTH	☐	☐
Do you have sore or lesion on lips or mouth for more than 2 wks	☐	☐
Do you have chronic horseness	☐	☐
Do you have lump or thickening in the cheek	☐	☐
Do you snore or have you been told you snore?	☐	☐
Is there a history of heart disease in your immediate fami	☐	☐
Do you have a family history of diabetes?	☐	☐

MEDICAL HISTORY

PLEASE ✓ YES OR NO OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

	YES	NO		YES	NO
AIDS/HIV Pos.	☐	☐	Hepatitis	☐	☐
Anaphylaxis	☐	☐	High Blood Pressure	☐	☐
Anemia	☐	☐	High Cholesterol	☐	☐
Arthritis (Rheumatism)	☐	☐	Jaw pain	☐	☐
Artificial heart valves	☐	☐	Kidney disease or malfunction	☐	☐
Artificial joints	☐	☐	Liver Disease	☐	☐
Asthma	☐	☐	Mitral valve prolapse	☐	☐
Atopic (allergy prone)	☐	☐	Nervous problems	☐	☐
Back Problems	☐	☐	Pacemaker/heart surgery	☐	☐
Blood Disease	☐	☐	Psychiatric care	☐	☐
Cancer	☐	☐	Rapidweight gain/loss	☐	☐
Chemical dependency	☐	☐	Radiation Treatment	☐	☐
Chemotheraphy	☐	☐	Respiratory disease	☐	☐
Circulatory problems	☐	☐	Rheumatic/scarlet fever	☐	☐
Cortisone treatments	☐	☐	Shingles	☐	☐
Cough (persistent)	☐	☐	Shortness of breath	☐	☐
Cough up blood	☐	☐	Skin rash	☐	☐
Diabetes	☐	☐	Sleep Apnea	☐	☐
Epilepsy	☐	☐	Spina Bifida	☐	☐
Fainting	☐	☐	Stroke	☐	☐
Food Allergies	☐	☐	Surgical Implant	☐	☐
Glaucoma	☐	☐	Swelling of feet/ankles	☐	☐
Heart Murmur	☐	☐	Thyroid disease/malfunction	☐	☐
Heart problems (pls describe)	☐	☐	Tonsillitis	☐	☐
_____			Tubercolosis	☐	☐
Hemophilia (abnormal bleeding)	☐	☐	Ulcer Colitis	☐	☐
Herpes	☐	☐	Venereal disease	☐	☐

Is there any other Medical or dental info that you feel I should know about ☐ ☐

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibilty to inform the office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature (patient or paprent/guardian) _____ Date _____

Doctor's Signature _____ Date _____