

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.

MEDICAL HISTORY

- Are you in good health?Yes No
1. Date of last physical examination _____
 2. Are you under the care of a physician?Yes No
 3. If so, what is the condition being treated? _____
Name of Physician _____ Address _____ City _____ Zip _____ Phone# _____
 4. Have you ever had any serious illness or operation? Yes No
If so, what was the illness? _____
 5. Have you ever been hospitalized?Yes No
If so, what was the problem? _____
 6. Are you taking any medication or recreational drugs?Yes No
 7. Are you sensitive or allergic to any of the following? ___ Penicillin ___ Tetracycline ___ Sulfa Drugs ___ Aspirin ___ Codeine ___ Latex Other _____
 8. Have you ever taken prescriptive diet medication/s?Yes No

Do you have or have you had any of the following: (Please circle Y or N for all conditions listed below.)

- | | | | | |
|--------------------|-------------------|-------------------------|---------------------------|---------------------------|
| Y N Anemia | Y N Cold Sores | Y N Sinus Trouble | Y N Blood Transfusion | Y N Chemotherapy |
| Y N Herpes | Y N Hemophilia | Y N Blood Disease | Y N Joint Replacement | Y N Psychiatric Treatment |
| Y N Stroke | Y N Rheumatism | Y N Drug Addiction | Y N Nervous Disorders | Y N Thyroid Disease |
| Y N Ulcers | Y N Heart Murmur | Y N Tumors or Growths | Y N Respiratory Disease | Y N Chicken Pox |
| Y N Kidney Disease | Y N Tuberculosis | Y N Sickle Cell Disease | Y N Fainting Spells | Y N Excessive Bleeding |
| Y N Diabetes | Y N Bruise easily | Y N Stomach Ulcers | Y N Allergies or Hives | Y N Venereal Disease |
| Y N Glaucoma | Y N Head Injuries | Y N Angina Pectoris | Y N Epilepsy or Seizures | Y N Hepatitis or Jaundice |
| Y N Arthritis | Y N Heart Failure | Y N Mental Disorder | Y N Cortisone Medication | Y N HIV / AIDS |
| Y N Hay Fever | Y N Liver Disease | Y N Asthma | Y N Artificial Prosthesis | Y N Cerebral Palsy |
| Y N Tonsillitis | Y N Scarlet Fever | Y N Rheumatic Fever | Y N other _____ | |

9. Do you wear a cardiac pacemaker, or have you had heart surgery? Yes No
10. Do you have any disease, condition or problem not listed that you think I should know about?
If so, please indicate _____
11. (Women) Is there a possibility you may be pregnant? Yes No If so, how many months? _____ months
12. (Women) Do you have any problems associated with your menstrual period? Yes No
13. (Women) Do you take Birth Control pills? Yes No

DENTAL HISTORY

1. Have you ever had a local anesthetic (Novocaine, etc.)? Yes No
2. Have you ever had any unfavorable reaction from a local anesthetic? Yes No
3. Have you ever had any serious trouble associated with any previous dental treatment? Yes No
If so, explain _____
4. How long since your last full mouth X-Rays? _____
5. How long since your last dental treatment? _____
6. Does dental treatment make you nervous? Yes No
If yes, check: ___ Slightly ___ Moderately ___ Extremely

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health or if my medications change, I will, without fail, inform the doctor at my next appointment.

Date _____ Signature _____

CONSENT FOR TREATMENT: I hereby grant authority to the dentist (s) in charge of the care of the patient whose name on this Health History form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation: and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs
"All services are rendered and accepted under the terms and conditions printed on the reverse hereof"

Signed: _____ Date: _____
Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when patient is physically or mentally incompetent.

Relationship to the patient: _____

Office Use Only

Patient Chart # _____

I verbally reviewed the medical / dental information above with the patient named herein or if minor, patient / guardian.

Doctor's comment _____

Dr. _____

Date _____