HEALTH QUESTIONNAIRE

Patient Name_____
Sex_____Age____Height_____Weight_____
Date_____ Occupation_____
Marital Status_____

Directions

Please circle the appropriate answer to the questions and fill in the blanks where indicated. Answer all questions and blanks completely.

Answers to the following questions are for our records and will be considered confidential.

1. Are you in good health..... Yes No
   A. Has there been any change in your general health..... Yes No
2. My last physical examination was on _____
3 Are you now under care of a physician..... Yes No
   A. If so, what is the condition being treated
   _____
4. The name and address of my physician is
   _____
   _____
5. Have you had any serious illness or operation..... Yes No
   A. Is so, what was the illness or operation:_____
   _____
   _____
6. Have you been hospitalized or had serious illness within the last (5) years..... Yes No
   A. Do you have a persistent cough or cough up blood..... Yes No
   B. Low Blood Pressure..... Yes No
   C. Venereal Disease..... Yes No
   D. Aids or HIV..... Yes No
   E. Other _____
   _____
7. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma..... Yes No
   A. Do you bruise easily..... Yes No
   B. Have you ever requires a blood transfusion..... Yes No
   If so, explain the circumstances_____
   _____
8. Do you have any blood disorder such as anemia..... Yes No
9. Have you had surgery or X-ray treatment for a tumor, growth or other condition of your mouth or lips..... Yes No
10. Are you taking any drug or medication..... Yes No
    If so, what_____
    _____
11. Are you taking any of the following:
    A. Antibiotics or sulfa drugs..... Yes No
    B. Anticoagulants (blood thinners)..... Yes No
    C. Medicine for high blood pressure..... Yes No
    D. Cortisone (steroids)..... Yes No
    E. Tranquilizers..... Yes No
    F. Aspirin..... Yes No
    G. Insulin, Tolbutamide (Orinasc) or similar drug..... Yes No
    H. Digitalis or drugs for heart trouble..... Yes No
    I. Nitroglycerin..... Yes No
    J. Fen-phen (now, or in the past)..... Yes No
    K. Oral contraceptives..... Yes No
    If so, what are you using _____
    _____
    L. Other_____
    _____
12. Do you have heart murmur/mitral valve prolapse.... Yes No
13. Do you have any implants and/or prosthesis (i.e. knee joints, elbow pins, etc.)..... Yes No
    If so. explain _____
14. Do you drink any alcoholic beverages..... Yes No
15. Do you smoke..... Yes No
    If so, how much_____
16. Do you have or have had any of the following diseases or problems:
    A. Rheumatic fever or rheumatic heart disease..... Yes No
    B. Congenital heart lesions..... Yes No
    C. Cardiovascular disease (heart trouble, heart attack, coronary occlusion, high blood pressure, arteriosclerosis, stroke)..... Yes No
    1. Do you have pain in the chest upon exertion ..... Yes No
    2. Are you ever short of breath after mild exercise..... Yes No
    3. Do you get short of breath when you lie down or do you require extra pillows when you sleep..... Yes No
    D. Allergy..... Yes No
    E. Asthma or hay fever..... Yes No
    F. Hives or skin rash..... Yes No
    G. Fainting spells or seizures..... Yes No
    H. Diabetes..... Yes No
    1. Do you have to urine (pass water) more than six times a day..... Yes No
    2. Are you thirsty much of the time..... Yes No
    3. Does your mouth frequently become dry..... Yes No
    I. Hepatitis, jaundice or liver disease..... Yes No
    J. Arthritis..... Yes No
    K. Inflammatory rheumatism (painful, swollen joints)... Yes No
    L. Stomach Ulcers..... Yes No
    M. Kidney Trouble..... Yes No
    N. Tuberculosis..... Yes No
17. Are you allergic or have reacted adversely to:
    A. Local anesthetic..... Yes No
    B. Penicillin or other antibiotics..... Yes No
    C. Barbiturates, sedatives, or sleeping pills..... Yes No
    D. Sulfa drugs..... Yes No
    E. Aspirin..... Yes No
    F. Iodine..... Yes No
    G. Latex..... Yes No
    H. Other_____
    _____
18. Have you had any serious trouble associated with previous dental treatment..... Yes No
    If so, Explain_____
    _____
19. Are you pregnant or could you be..... Yes No
    If so, when are you due?_____

I certify to the best of my knowledge that the above information is correct and that if there are any changes in the above, I agree to notify my dentist before my next visit.

Patient/Guardian_____Date_____

Doctor_____Date_____

Updates:

Patient/Guardian_____Doctor's Initials____Date_____

Patient/Guardian_____Doctor's Initials____Date_____

Patient/Guardian_____Doctor's Initials____Date_____

PATIENT INFORMATION

PATIENT'S NAME _____
RESIDENCE ADDRESS _____
CITY _____ STATE _____ ZIP _____
ADULT _____ CHILD _____ MALE ____ FEMALE ____ MARRIED ____ SINGLE _____
DATE OF BIRTH _____ AGE _____
DRIVER LICENSE # _____ SOCIAL SECURITY # _____
HOME PHONE _____ WORK PHONE _____
CELL PHONE _____
EMERGENCY CONTACT NAME _____
WHO MAY WE THANK FOR REFERRING YOU? _____

FAMILY RECORD FOR MINOR CHILD

SPOUSE/FATHER FULL NAME _____ PHONE _____
ADDRESS IF DIFFERENT _____
EMPLOYED BY _____ WK PHONE _____
SPOUSE/MOTHER FULL NAME _____ PHONE _____
ADDRESS IF DIFFERENT _____
EMPLOYED BY _____ WK PHONE _____
GUARDIAN LEGAL NAME _____ PHONE _____

FINANCIAL & INSURANCE INFORMATION

NAME OF POLICY HOLDER _____
NAME OF EMPLOYER _____
DATE OF BIRTH OF INSURED _____ SS# _____
NAME OF INSURANCE CO. _____ PHONE _____
GROUP # _____ ID # _____
ARE YOU COVERED BY ANOTHER INSURANCE PLAN?
NAME OF POLICY HOLDER _____ YES or NO
NAME OF EMPLOYER _____
DATE OF BIRTH OF INSU RED _____ SS# _____
NAME OF INSURANCE CO. _____ PHONE _____
GROUP # _____ ID # _____
ARE YOU COVERED BY ANOTHER INSURANCE PLAN? YES or NO
NAME OF POLICY HOLDER _____
NME OF EMPLOYER _____
DATE OF BIRTH OF INSURED _____
SOCIAL SECURITY# _____
NAME OF INSURANCE CO. _____
DO YOU HAVE MEDICAL? YES or NO
DO YOU HAVE HEALTHY FAMILIES INSURANCE? YES or NO
NAME _____
SOCIAL SECURITY# _____
ID# _____
DATE OF BIRTH _____