Health Questionnaire

Patient name _____

Answers to the following questions are for our records and will be considered confidential. Please circle answer to the question.

1. Are you in good health? Yes No

2. My last physical examination was on _____

3. Are you now under the care of a physician Yes No

If so what is the condition _____

4. The name and number of my physician is:_____

5. Have you had a serious illness or operation Yes No

If so, what was it

_____

_____

6. Do you have a persistent cough or cough up blood Yes No

7. Low blood pressure Yes No

8. Venereal Disease Yes No

9. AIDS OR HIV+ Yes No

10. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma Yes No

11. Do you have any blood disorder such as anemia Yes No

12. Are you taking any of the following medication:

Antibiotics or sulfa drugs Yes No

Anticoagulants (blood thinners) Yes No

Medicine for high blood pressure Yes No

Cortisone (steroids) Yes No

Tranquilizers Yes No

Aspirin Yes No

Insulin, Tolbutamide (Orinase) or similar Yes No

Digitalis or drugs for heart trouble Yes No

Nitroglycerin Yes No

Fen-Phen or any related drugs such as Ionimin, Adipex, Phentermine, Fastin, Pondimin, and Redux Yes No

Oral Contraceptives Yes No

Other

_____

13. Do you have a heart murmur/mitral valve prolapsed

Yes No

14. Do you have any implants and/or prosthesis Yes No

If so, explain_____

15. Do you drink alcoholic beverages Yes No

16. Do you smoke Yes No

If so, how much_____

17. Do you have any of the following diseases or problems:

Rheumatic fever or rheumatic heart disease Yes No

Congenital heart lesions Yes No

Cardiovascular disease (heart trouble, heart attack, coronary occlusion, arteriosclerosis, stroke) Yes No

Asthma or hay fever Yes No

Hives or skin rash Yes No

Fainting spells or seizures Yes No

Diabetes Yes No

Hepatitis, jaundice, or liver disease Yes No

Arthritis Yes No

Inflammatory rheumatism Yes No

Stomach ulcers Yes No

Kidney trouble Yes No

Tuberculoses Yes No

18. Are you allergic or have you reacted adversely to:

Local anesthetic Yes No

Penicillin or other antibiotics Yes No

Barbiturates, sedatives, or sleeping pills Yes No

Sulfa Drugs Yes No

Aspirin Yes No

Iodine Yes No

Latex Yes No

Other_____

19. Have you had any serious trouble associated with previous dental treatment Yes No

If so, explain_____

20. Are you pregnant 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 on the above, I agree to notify my dentist before my next visit

Patient/Guardian _____Date_____

Doctor _____Date_____