



HEALTH QUESTIONNAIRE

Patient Name _____ DOB _____

Your Physician's Name _____ Phone # _____

Your Physician's Address _____

How would you describe your present health? EXCELLENT GOOD FAIR POOR

DO YOU NEED TO PRE-MEDICATE? _____ Yes _____ No

Check any of the following which apply to you:

- | | | |
|---------------------------------|---|---------------------------------------|
| _____ Heart Trouble | _____ Diabetes | _____ Tuberculosis |
| _____ Congenital Heart Problems | _____ Jaundice | _____ Kidney Disease |
| _____ Heart Murmur | _____ Hepatitis | _____ Arthritis |
| _____ Heart Surgery | _____ Cancer | _____ Joint Replacement Prosthesis |
| _____ Rheumatic Fever | _____ Glaucoma | _____ Stroke |
| _____ Cardiac Pacemaker | _____ Sinus Trouble | _____ Epilepsy |
| _____ Heart Valve Prosthesis | _____ Persistent Cough | _____ Treatment for Nervous Condition |
| _____ High Blood Pressure | _____ Asthma | _____ Mitral Valve Prolapse |
| _____ Low Blood Pressure | _____ HIV Infection | _____ Blood Transfusion |
| _____ Stomach Ulcers | _____ Venereal Disease/Other Sexually Transmitted Disease | |

1. Have you had a recent complete physical examination? _____ When? _____

2. Has there been any change in your general health in the last year? _____ Explain? _____

3. Have you been under a doctor's care, been hospitalized or seriously ill during the past two years? _____

Explain _____

4. Do you take any medications or drugs, including aspirin, vitamins, hormones, antacids, steroids or birth control pills, presently or within the last six months? _____

Drug	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. Are you allergic or have you experienced an unusual reaction to any drugs? _____ Please List _____

6. Have you experienced any other allergic reactions _____ Please List: _____

7. Have you experienced excessive bleeding that required special treatment? _____ Explain: _____

8. Is there a history of diabetes in your immediate family? _____

9. Are you required to restrict your diet, work or activities in any way? _____ Explain: _____

10. Do you smoke cigarettes? _____ Cigars? _____ Pipe? _____ How many per day? _____ How long? _____

11. Have you every been treated for a growth or tumor in any part of your body? _____ Explain: _____

12. Do you have frequent headaches? _____ Migraines? _____ What area of the head? _____

Do you have any disease, condition or problem not listed above that you feel we should know about? If so, please explain:

WOMEN: Are you pregnant? _____ Due Date: _____

Have you reached menopause? _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

DENTAL HEALTH HISTORY

Check any of the following which you may have had or experienced:

- | | | |
|--|--|---|
| <input type="checkbox"/> Injury to Face or Jaw | <input type="checkbox"/> Sensitivity to Hot | <input type="checkbox"/> Aches in Jaw Joint |
| <input type="checkbox"/> Slow Healing Mouth Sores | <input type="checkbox"/> Sensitivity to Cold | <input type="checkbox"/> Clicking/Popping in Jaw |
| <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Mouth Odor | <input type="checkbox"/> Jaw Locking – Open or Closed |
| <input type="checkbox"/> Mouth Ulcers | <input type="checkbox"/> Bad Taste in Mouth | <input type="checkbox"/> Change in Bite |
| <input type="checkbox"/> Swollen Gums | <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Loose Teeth |
| <input type="checkbox"/> Tired Jaw or Sore Muscles | | |

Which of the following do you use on a daily basis?

- | | | |
|-------------------------------------|---|--|
| <input type="checkbox"/> Toothbrush | <input type="checkbox"/> Proxabrush | <input type="checkbox"/> Fluoride Rinse |
| <input type="checkbox"/> Toothpicks | <input type="checkbox"/> End-Tuft Brush | <input type="checkbox"/> Mouthwash (what type) _____ |
| <input type="checkbox"/> Floss | <input type="checkbox"/> Stimudents | <input type="checkbox"/> Other: _____ |

- If you are currently experiencing pain in your mouth, where is it located? _____
- How did it come to your attention that you have a periodontal problem? _____
- Do you feel strongly about keeping your teeth for the rest of your life? _____
- Are you happy with the appearance of your teeth? _____
- Have you had orthodontic therapy (braces)? _____ Type? _____ When? _____
- Have you had previous periodontal (gum) treatment? _____ Type: _____ When? _____
- Have you had oral surgery? _____ Type? _____ When? _____
- Have you had crown and/or bridge work? _____ When? _____
- Have you ever worn a bite guard, bite plane or night guard? _____ When? _____
- Have you ever noticed any change in the position of your teeth? _____ Explain? _____
- Do you have difficulty in chewing? _____ Explain: _____
- Is it difficult to open your mouth wide? _____
- Are you worried about receiving dental treatment? _____ If so, what is your main concern? _____
- Has any family member had similar periodontal signs/symptoms? _____

Present Dentist: _____ How long? _____

Last Dental Treatment: _____ For what? _____

Last Cleaning: _____ Last x-rays: _____

Pattern of Dental Care: _____ regular _____ sporadic _____ infrequent

Nutritional Evaluation:

- How many meals do you usually have per day? _____
- Would you consider your diet "well balanced?" _____
- Are you on any special diets? _____
- Do you eat sweets, drink sugared drinks frequently? _____
- Do you drink alcohol? _____ How often per week: _____
- Would you consider your job stressful? _____

OFFICE USE

Date: _____ Temp: _____ Blood Pressure: _____

Heart Rate: _____ ASA Class: I II III IV

Reasons: _____

Chief Complaint: _____