



HEALTH QUESTIONNAIRE

Patient Name _____ Today's Date ____/____/____

Physician Name _____ Physician Phone #: (____) _____

Please circle your response: Do you now or have you ever had any of the following diseases or conditions?

Aids (HIV)	Yes	No	Kidney disease or infection	Yes	No
Asthma	Yes	No	Liver Disease	Yes	No
Bladder Disease or infection	Yes	No	Measles	Yes	No
Blood Disorders	Yes	No	Mumps	Yes	No
Chicken Pox	Yes	No	Painful or swollen joints	Yes	No
Diabetes (Sugar disease)	Yes	No	Polio	Yes	No
Epilepsy	Yes	No	Rheumatic Fever	Yes	No
Glaucoma	Yes	No	Seizures	Yes	No
Heart Attack	Yes	No	Severe Headaches	Yes	No
Hemophilia	Yes	No	Sexually Transmitted Disease	Yes	No
Hepatitis A ,B ,C	Yes	No	Stroke	Yes	No
Herpes	Yes	No	Tuberculosis	Yes	No
Jaundice (Yellow skin or eyes)	Yes	No	Ulcers	Yes	No

Have you ever been told by a physician that you have a heart murmur?Yes/No
Has your physician recommended pre-medication with antibiotics before dental treatment? Yes/No

Do you now have or have you ever had any heart trouble? (i.e. Rheumatic fever, angina, etc.).....Yes/No
 Do you have any **allergies (to latex, metal, etc)? Yes/No Please List** _____

Have you ever experienced any unusual **reactions or allergies** to any of the following drugs?

Penicillin	Yes	No	Novocain	Yes	No
Antibiotics	Yes	No	Sulfa drugs	Yes	No
Aspirin	Yes	No	Others:PleaseList		

Do you have high blood pressure? Yes/No

Do you have any artificial prostheses in your body? (i.e. metal screws, plates, joints etc.) Yes/No

*** If YES,** please specify _____

Do you now or have you ever used tobacco products? Yes/No

Have you been examined by a physician within the last year? Yes/No

Have you ever been hospitalized?..... Yes/No

***If YES,** please explain _____

Have you ever had a blood transfusion? Yes/No

Have you ever been treated for a growth or tumor in any part of your body? Yes/No

Women – Are you presently pregnant?..... Yes/No

Girls– Have you begun menstrual periods?..... Yes/No

Please list all current medications and herbal or supplements you are currently taking:

Name of Medication/Supplement	Dosage/mg	Frequency	Condition
_____	_____	_____	_____
_____	_____	_____	_____

I understand that the information that I have given 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 responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

Patient signature (Parent if a minor) _____ Date _____