HEALTH QUESTIONNAIRE **DATE:**

Patient Name _____ Referred by: _____
Date of Birth: _____ Emergency Contact:_____
Address _____ City _____ Zip _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____

DENTAL AND MEDICAL HISTORY Insurance: _____ ID#: _____

Do you have or have you ever had problems with any of the following?

☐ Bad Breath
☐ Bleeding Gums
☐ Blisters on Mouth
☐ Burning sensation on tongue
☐ Chew on one side of mouth
☐ Clicking or popping Jaw
☐ Dry Mouth
☐ Food collection between teeth
☐ Grinding Teeth
☐ Gums swollen and tender
☐ Loose teeth or broken fillings
☐ Mouth Pain when Brushing
☐ Orthodontic treatment
☐ Pain around ear
☐ Periodontal treatment
☐ Sensitivity to cold or hot
☐ Sensitivity to sweets
☐ Sensitivity when biting
☐ Sores or growths in your mouth
☐ Other _____
☐ None of the above

☐ Allergies (latex, food, other)
☐ Anemia
☐ Arthritis, Rheumatism
☐ Asthma
☐ Back Problems
☐ Blood Disorders/Disease
☐ Cancer
☐ Chemical Dependency
☐ Chemotherapy
☐ Circulatory Problems
☐ Cortisone Treatments
☐ Cough, Persistent
☐ Coughing up Blood
☐ Diabetes
☐ Epilepsy
☐ Fainting/Dizziness
☐ Glaucoma
☐ Headaches
☐ Heart Problems
☐ Hemophilia
☐ Hepatitis
☐ Herpes
☐ High Blood Pressure
☐ HIV/AIDS
☐ Jaw Pain/TMJ
☐ Kidney/Liver Disease
☐ Mitral Valve Prolapse
☐ Pacemaker
☐ Port/Stint Access
☐ Radiation Treatment
☐ Respiratory Disease
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Shortness of Breath
☐ Sinus Trouble
☐ Skin Rash
☐ STDs/Venereal Disease
☐ Stroke
☐ Swollen Feet or Ankles
☐ Swollen Neck Glands
☐ Thyroid Problems
☐ Tobacco Habit
☐ Tonsillitis
☐ Tuberculosis
☐ Tumors/Growths
☐ Other _____
_____
_____
☐ None of the above

Physician's Name and phone number _____ Date of last visit _____
Please list medications you are currently taking: _____
Have you ever had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____
_____
Have you ever been told by a doctor that you should take antibiotics prior to dental appointments? ☐Yes ☐No
Do you have any artificial joints or pins? ☐Yes ☐No
(Women) Are you pregnant? ☐Yes ☐No Nursing? ☐Yes ☐No Taking birth control pills? ☐Yes ☐No

Do you have or have you ever had a reaction to any of the following medications?

☐ Aspirin
☐ Barbiturates (Sleeping Pills)
☐ Codeine
☐ Epinephrine
☐ Iodine
☐ Local Anesthetic
☐ Novocaine
☐ Penicillin
☐ Sulfa
☐ Other _____
_____
☐ None of the above

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____
Signature of Patient, Parent, Guardian or Personal Representative Relationship to Patient Date

Changes in above information _____
_____Date _____ Signature:_____
Changes in above information _____
_____Date _____ Signature:_____
Changes in above information _____
_____Date _____ Signature:_____