Health Questionnaire

Patient's Name_____ **Birth date** _____

All information you provide will be kept confidential.

1. Are you in good health?_____
2. Has there been any change in your general health in the past year?_____
3. Date of last check up by physician:_____
4. Are you currently under a physician's care?_ _____
   If so, what for? _____
   Treating Physician's name?_____ Phone # _____
5. Have you had any serious illness, operations, or hospitalizations?_ _____
   If yes, describe and give approximate dates_____
6. Has your physician recommended premedication before dental treatment? _____ If so, for what?
   _____
7. DO YOU HAVE OR HAVE YOU EVER HAD:

Heart (Disease/Surgery/Attack)	☐	Ulcers	☐	Kidney Disease	☐
Chest Pain	☐	Diabetes	☐	AIDS/HIV positive	☐
Congenital Heart Disease	☐	Stroke	☐	Swollen Ankles	☐
Cortisone (Steroid) Medicine	☐	Chronic Cough	☐	Artificial Joints	☐
Thyroid Problems	☐	Emphysema	☐	Hay Fever/Allergies	☐
Hepatitis A B C	☐	Tuberculosis	☐	Osteoporosis	☐
High/Low Blood Pressure	☐	Hemophilia	☐	Sickle Cell Disease	☐
Arthritis/Rheumatism	☐	Bruise Easily	☐	Liver Disease/Jaundice	☐
Artificial Heart Valve/Pacemaker	☐	Fainting/Dizzy	☐	Epilepsy/Seizures	☐
Chemotherapy/Radiation Therapy	☐	Tumors/Cancer	☐	Asthma	☐
Sleep Apnea/CPAP	☐	Recurrent Infections	☐	Sinus Trouble	☐

Any disease, drug or transplant operation that has depressed your immune system?_ ___
Please describe _____

LIST ALL CURRENT MEDICATIONS/VITAMINS HERE (attach additional pages if necessary)

7. ARE YOU ALLERGIC TO OR HAD A BAD REACTION FROM TAKING ANY MEDICATION?Please list_____
8. ARE YOU ALLERGIC TO LATEX? _____
9. Do you use any form of tobacco? Type _____ Frequency _____For how long? _____
10. Are you, or have you been, in a drug or alcohol recovery program?_____
11. Do you have any other disease, condition, or problem not listed that you think the doctor should know about? Please list _____

WOMEN Are you

Pregnant-week_____ Breastfeeding ☐ Taking Birth Control Pills ☐ Taking hormone replacement ☐

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.

_____ _____
Date Signature of Patient/Parent/Guardian