

# HEALTH QUESTIONNAIRE

Name \_\_\_\_\_ Birth date \_\_\_\_\_

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Circle yes or no, whichever applies, in response to the following questions. Your answers are for our records only and will be considered confidential.

## DENTAL

1. Are you having any discomfort at this time ..... Yes No
2. Have you ever had any serious trouble associated with previous dental treatment? ..... Yes No  
If so explain? \_\_\_\_\_
3. Does dental treatment make you nervous? No \_\_\_\_\_ Slightly \_\_\_\_\_ Moderately \_\_\_\_\_ Extremely \_\_\_\_\_
4. Date of last dental visit \_\_\_\_\_
5. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? ..... Yes No  
If so when? \_\_\_\_\_
6. How often do you brush \_\_\_\_\_  
Brush is: Soft  Medium  Hard
7. Do you have or have you ever had any of the following?

### MOUTH

- |   |     |    |
|---|-----|----|
| Bleeding, sore gums .....               | Yes | No |
| Unpleasant taste/bad breath .....       | Yes | No |
| Burning tongue/lips .....               | Yes | No |
| Frequent blisters, lip/mouth .....      | Yes | No |
| Swelling/lumps in mouth .....           | Yes | No |
| Ortho treatments (braces) .....         | Yes | No |
| Biting cheeks/lips .....                | Yes | No |
| Clicking/popping jaw .....              | Yes | No |
| Difficulty opening or closing jaw ..... | Yes | No |

8. Do you use the following?

- |                      |     |    |
|----------------------|-----|----|
| Brush .....          | Yes | No |
| Dental floss .....   | Yes | No |
| Fluoride rinse ..... | Yes | No |
| Other .....          |     |    |

### TEETH

- |                           |     |    |
|---------------------------|-----|----|
| Loose teeth .....         | Yes | No |
| Sensitive to hot .....    | Yes | No |
| Sensitive to cold .....   | Yes | No |
| Sensitive to sweets ..... | Yes | No |
| Sensitive to biting ..... | Yes | No |
| Food impaction .....      | Yes | No |
| Clenching/grinding .....  | Yes | No |
| If so, when _____         |     |    |
| Shifting in bite .....    | Yes | No |
| Change in bite .....      | Yes | No |

## MEDICAL

1. Has there been any change in your general health within the past year ..... 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 being treated \_\_\_\_\_
  4. The name and address of my physician is \_\_\_\_\_
  5. Have you had any serious illness within the past five (5) years ..... Yes No  
If so, what was the illness \_\_\_\_\_
  6. Have you been hospitalized or had an operation within the past five (5) years ..... Yes No  
If so, what was the problem \_\_\_\_\_
  7. Do you have or have you had any of the following diseases or problems
- |  |     |    |
|--|-----|----|
| a. Rheumatic fever or rheumatic heart disease .....  | Yes | No |
| b. Congenital heart disease .....  | Yes | No |
| c. Cardiovascular disease (heart trouble, heart attack, heart murmur, coronary insufficiency, coronary occlusion, high/low blood pressure, arteriosclerosis, stroke, etc.) ..... | Yes | No |
| 1) Do you have pain in chest upon exertion .....   | Yes | No |
| 2) Are you ever short of breath after mild exercise .....  | Yes | No |
| 3) Do your ankles swell .....  | Yes | No |
| 4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep .....  | Yes | No |
| d. Artificial or replacement valves .....  | Yes | No |
| e. Pacemaker .....   | Yes | No |
| f. Allergy .....   | Yes | No |
| g. Sinus trouble .....   | Yes | No |
| h. Asthma or hay fever .....   | Yes | No |
| i. Hives or a skin rash .....  | Yes | No |
| j. Fainting spells or seizures .....   | Yes | No |
| k. Diabetes .....  | Yes | No |
| 1) Do you have to urinate (pass water) more than six times a day .....   | Yes | No |
| 2) Are you thirsty much of the time .....  | Yes | No |
| 3) Does your mouth frequently become dry .....   | Yes | No |

- |   |     |    |
|---|-----|----|
| l. Hepatitis, jaundice or liver disease .....   | Yes | No |
| m. Arthritis or inflammatory rheumatism .....   | Yes | No |
| n. Artificial or replacement joints, prosthetic .....   | Yes | No |
| o. Digestive system—Ulcers or stomach disorders (colitis) .....   | Yes | No |
| p. Kidney trouble .....   | Yes | No |
| q. Tuberculosis .....   | Yes | No |
| r. Persistent cough or cough up blood .....   | Yes | No |
| s. Immune System disorders (including AIDS, HIV, ARC) .....   | Yes | No |
| t. Venereal disease .....   | Yes | No |
| u. Other .....  |     |    |
| 8. Have you had abnormal bleeding associated with previous extractions, surgery or trauma? .....              | Yes | No |
| a. Do you bruise easily .....   | Yes | No |
| b. Have you ever required a blood transfusion .....   | Yes | No |
| If so, explain the circumstances & when .....   |     |    |
| 9. Have you ever tested positive for the AIDS virus? .....  | Yes | No |
| 10. Do you have any blood disorder such as anemia? .....  | Yes | No |
| 11. Have you had surgery or x-ray treatment for a tumor, growth, or other condition? .....                    | Yes | No |
| 12. Are you taking any of the following:  |     |    |
| a. Antibiotics or sulfa drugs .....   | Yes | No |
| b. Anticoagulants (blood thinners) .....  | Yes | No |
| c. Medicine for high blood pressure .....   | Yes | No |
| d. Cortisone (steroids) .....   | Yes | No |
| e. Tranquilizers .....  | Yes | No |
| f. Antihistamines .....   | Yes | No |
| g. Aspirin .....  | Yes | No |
| h. Insulin, tolbutamide (Orinase) or similar drug for diabetes .....  | Yes | No |
| i. Digitalis or drugs for heart trouble .....   | Yes | No |
| j. Nitroglycerin .....  | Yes | No |
| k. Other medications .....  | Yes | No |
| l. If "Yes" to any of the above, state drug name, dosage and frequency .....                                  |     |    |
| 13. Are you allergic or have you reacted adversely to:  |     |    |
| a. Local anesthetics .....  | Yes | No |
| b. Penicillin or other antibiotics .....  | Yes | No |
| c. Sulfa drugs .....  | Yes | No |
| d. Barbiturates, sedatives, or sleeping pills .....   | Yes | No |
| e. Aspirin .....  | Yes | No |
| f. Iodine .....   | Yes | No |
| g. Codeine or other narcotics .....   | Yes | No |
| h. Other .....  |     |    |
| 14. Do you use any tobacco products .....   | Yes | No |
| If so, how much per day and what .....  |     |    |
| 15. Do you use any alcohol products .....   | Yes | No |
| If so, how much per day/week/month and what .....   |     |    |
| 16. Do you use any caffeinated products (coffee, tea, chocolate, etc.) .....                                  | Yes | No |
| If so, how much per day and what .....  |     |    |
| 17. Do you have any disease, condition, or problem not listed above that you think I should know about? ..... | Yes | No |
| If so, explain .....  |     |    |
| 18. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation ..... | Yes | No |
| 19. Are you wearing contact lenses .....  | Yes | No |
| 20. Are you experiencing stress or pressure in your work or at home .....                                     | Yes | No |

**WOMEN**

- |   |     |    |
|---|-----|----|
| 20. Are you pregnant .....  | Yes | No |
| 21. Do you have PMS or problems associated with your menstrual period ..... | Yes | No |
| 22. Are you taking birth control or hormone therapy .....                   | Yes | No |

Remarks:

*To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.*

Signature of Patient

Date

Signature of Dentist

Date