HEALTH QUESTIONNAIRE

Please fill out your dental and medical histories to the best of your ability.
This information is confidential!

DENTAL HISTORY

Reason for today's visit:_____ Date of last dental visit:_____

Treatment done at last visit:_____ Date of last X-rays:_____

Your dentist(s):_____ Phone: (____)_____

Are you anxious/ nervous about receiving dental treatment? ☐Yes ☐No ☐Somewhat
Have you had a bad experience with dental treatment? ☐Yes ☐No
Are you happy with your smile? ☐Yes ☐No ☐Somewhat

Check all the problems you have: ☐ I have none of these

☐ Bleeding gums	☐ Bad breath	☐ Hot/cold sensitivity	☐ Sweet sensitivity
☐ Food gets stuck between teeth	☐ Dry mouth	☐ Earaches	☐ Clicking/popping jaw
☐ Grind/clench teeth	☐ Sores in mouth	☐ Wear partials/dentures	☐ Uncomfortable bite
☐ Bad fillings/crowns/dentures	☐ Ugly fillings/crowns/dentures	☐ Dentures/partials don't fit well	☐ Swelling
☐ Stained/yellow teeth	☐ Spaces between teeth	☐ Crowded/overlapped teeth	☐ Had braces/retainers

☐ Pain/ache_____ ☐ Other_____

MEDICAL HISTORY

Your physician's name:_____ Date of last visit:_____

Reason for last visit:_____ Physician's phone: (____)_____

Do you see a physician regularly? ☐Yes ☐No If yes, for what?_____

Have you ever had any serious illness or operation? ☐Yes ☐No Have you ever been hospitalized? ☐Yes ☐No

If yes, describe (incl. date):_____

Have you ever had blood transfusions? ☐Yes ☐No Reason:_____ Approximate date:_____

Are you taking or have you ever taken: ☐ "fen-phen" ☐ Steroids ☐ Recreational drugs ☐ Bisphosphonates
☐ Fosamax (Alendronate) ☐ Actonel (Risedronate) ☐ Aredia ☐ Zometa

Check all problems/treatments you **have** or **have not had**:

☐Yes ☐No **Anemia**	☐Yes ☐No **Diabetes**	☐Yes ☐No **Jaw pain**	☐Yes ☐No **Sinus trouble**
☐Yes ☐No **Arthritis, Rheumatism**	☐Yes ☐No **Epilepsy**	☐Yes ☐No **Kidney Disease**	☐Yes ☐No **Skin rash**
☐Yes ☐No **Artificial Heart Valves**	☐Yes ☐No **Fainting/dizziness**	☐Yes ☐No **Liver Disease**	☐Yes ☐No **Special diet**
☐Yes ☐No **Artificial Joints**	☐Yes ☐No **Gastric Bypass**	☐Yes ☐No **Mitral Valve Prolapse**	☐Yes ☐No **Stomach Ulcer**
☐Yes ☐No **Asthma**	☐Yes ☐No **Glaucoma**	☐Yes ☐No **Osteoporosis**	☐Yes ☐No **Intestinal Ulcer**
☐Yes ☐No **Back problems**	☐Yes ☐No **Headaches**	☐Yes ☐No **Pacemaker**	☐Yes ☐No **Stroke**
☐Yes ☐No **Bleeding problems**	☐Yes ☐No **Heart murmur**	☐Yes ☐No **Panic/anxiety**	☐Yes ☐No **Thyroid Problems**
☐Yes ☐No **Blood disease**	☐Yes ☐No **Heart problems**	☐Yes ☐No **Tobacco/smoking**	☐Yes ☐No **Tonsillitis**
☐Yes ☐No **Cancer**	☐Yes ☐No **Hemophilia**	☐Yes ☐No **Psychiatric care**	☐Yes ☐No **Tuberculosis**
☐Yes ☐No **Chemical dependency**	☐Yes ☐No **Hepatitis**	☐Yes ☐No **Radiation treatment**	☐Yes ☐No **Tumor/growth**
☐Yes ☐No **Chemotherapy**	☐Yes ☐No **Herpes**	☐Yes ☐No **Respiratory disease**	
☐Yes ☐No **Circulatory problems**	☐Yes ☐No **High blood pressure**	☐Yes ☐No **Scarlet fever**	
☐Yes ☐No **Cortisone treatments**	☐Yes ☐No **HIV/AIDS**	☐Yes ☐No **Shortness of breath**	
☐Yes ☐No **Cough blood**		☐Yes ☐No **Rheumatic fever**	

☐ Other, please describe:_____

Women: *Are you pregnant*? ☐Yes ☐No ☐Possibly **/ *Take birth control pills*?** ☐Yes ☐No **/ *Nursing*?** ☐Yes ☐No
How many week/months of pregnancy: _____ <u>please circle</u>: *1st trimester / 2nd trimester / 3rd trimester*

List all prescription medications you are taking:_____

_____

List all over-the-counter medications and nutritional supplements you are taking:_____

_____

List all allergies you have:_____

_____

The information on this form is true and correct as of the date indicated below to the best of my knowledge. I understand that not reporting any conditions/medications/allergies may complicate my treatment, and may pose a serious health risk to me, and to the healthcare team.

_____ _____ _____
Patient's Name Signature (guardian, if patient under 18) Date

_____ _____
Medical History Reviewed Date

MEDICAL HISTORY UPDATE FORM **Date:** _____

Has there been any change in your health since your last dental appointment? (e.g. Pregnancy, Surgeries etc.) ☐Yes ☐No

If yes, for what?_____

Are you taking any kind of medications at this time? ☐Yes ☐No ☐No Change since Last Visit

If there are changes, please list_____

_____ _____

Patient Signature Doctor Signature

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