

## HEALTH QUESTIONNAIRE

Please answer the following questions by circling the best answer or by filling in the space provided with the appropriate information. If you have any questions please ask one of the desk personnel. Thank you.

Is your general health      Excellent \_\_\_\_\_    Good \_\_\_\_\_    Fair \_\_\_\_\_    Poor \_\_\_\_\_ ?

Name and address of physician \_\_\_\_\_

Date of Last Physical Examination \_\_\_\_\_

Yes    No    Are you presently under the care of a physician? For what? \_\_\_\_\_

Yes    No    Have you been hospitalized or had a serious illness in the past five (5) years? If Yes, year and reason \_\_\_\_\_

Do you have or have you had any of the following problems or diseases?

- Yes    No    Rheumatic Fever or Rheumatic heart problems  
Yes    No    Congenital heart problems  
Yes    No    Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high/low blood pressure, arteriosclerosis, stroke [circle all applicable])  
Yes    No    Heart Murmur  
Yes    No    Asthma or Hay fever  
Yes    No    Skin problems  
Yes    No    Fainting spells or seizures  
Yes    No    Diabetes  
Yes    No    Hepatitis, jaundice or liver disease  
Yes    No    Arthritis or rheumatism  
Yes    No    Stomach ulcers  
Yes    No    Kidney trouble  
Yes    No    Tuberculosis  
Yes    No    Epilepsy  
Yes    No    Venereal disease  
Yes    No    Tested Positive for any anti-immune deficiency diseases  
Yes    No    Is it possible that you could have been or can be exposed to AIDS?  
Yes    No    Other \_\_\_\_\_

Have you taken or are you now taking any of the following:

- Yes    No    Antibiotics or sulfa drugs  
Yes    No    Anticoagulants (blood thinners)  
Yes    No    Medicine for High Blood pressure  
Yes    No    Cortisone (steroids)  
Yes    No    Tranquilizers  
Yes    No    Aspirin  
Yes    No    Insulin, tolbutamide (Orinase) or similar drugs  
Yes    No    Digitalis or drugs for heart trouble  
Yes    No    Nitroglycerin  
Yes    No    Antihistamine  
Yes    No    Dilantin  
Yes    No    Other \_\_\_\_\_

Are you allergic or have you reacted to:

- Yes    No    Local anesthetics (novocain and xylocaine)  
Yes    No    Penicillin or any other antibiotics  
Yes    No    Sulfa drugs  
Yes    No    Barbiturates, sedatives or sleeping pills  
Yes    No    Aspirin  
Yes    No    Codeine or other narcotics  
Yes    No    Other \_\_\_\_\_  
Yes    No    Is your diet under the supervision of a physician?  
Yes    No    Are you dieting to lose weight?  
Yes    No    Do you have anemia or any other blood disorder?

Yes No Do you have a persistent cough?  
 Yes No Have you had surgery or x-ray treatment for a tumor, growth or other condition?  
 Yes No Are you employed in any situation, which regularly exposes you to x-rays or other ionizing radiation?  
 If you have any disease, condition or other problems not listed here that you think we should be aware of, please explain \_\_\_\_\_

**WOMEN**

Yes No Are you pregnant? If Yes, how many months \_\_\_\_\_  
 Yes No Do you have any problems associated with your menstrual period?  
 Yes No Are you currently going through or have completed menopause?  
 Yes No Are you or have you taken a hormonal supplement? Have you or  
 Yes No are you now taking birth control pills?

**CHILDREN**

Yes No Is this the first dental visit? If No, were previous visits pleasant or not, explain.  
  
 Yes No Is the child worried?  
 Yes No Does the child suck his/her thumb?  
 Yes No Does the child take a bottle to bed?  
 Yes No Is the child receiving fluoride? If yes, in drinking water or in supplements?

**DENTAL HISTORY**

When was your last visit to a dentist? \_\_\_\_\_ For what reason \_\_\_\_\_  
 \_\_\_\_\_

When was the last complete set of x-rays taken of your teeth?

0-1 year \_\_\_\_\_ 2 years \_\_\_\_\_ 3 or more years \_\_\_\_\_

How many times do you brush your teeth per day? \_\_\_\_\_

When did a hygienist, dentist or other health professional teach you how to brush and floss your teeth? \_\_\_\_\_

How often do you use dental floss? \_\_\_\_\_

How do like the appearance of your teeth? \_\_\_\_\_  
 \_\_\_\_\_

What is your opinion of your dental care? \_\_\_\_\_  
 \_\_\_\_\_

Yes No Have you often had severe toothaches?  
 Yes No Do your gums bleed or hurt when you brush or floss?  
 Yes No Have you been aware of any bad odor or taste in your mouth?  
 Yes No Have you ever had treatment for your gums?  
 Yes No Have you ever had orthodontic treatment or worn braces?  
 Yes No Do your teeth feel loose?  
 Yes No Are your teeth sensitive to heat, cold or sweets?  
 Yes No Do your teeth hurt when you chew?  
 Yes No Do your jaws hurt when you chew?  
 Yes No Have your teeth moved or drifted from their normal places?  
 Yes No Do you clamp, clench, or grind your teeth during the day or night?  
 Yes No Have you been aware of any swelling in your face or neck?  
 Yes No Do you have any pain or aching in cheeks, lips, tongue or jaws?  
 Yes No Do you have any problems with your speech?  
 Yes No Do you have any other serious or disabling tooth, gum or jaw problems?  
 Purpose of today's visit \_\_\_\_\_

Signature \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by \_\_\_\_\_ Date: \_\_\_\_\_