HEALTH QUESTIONNAIRE

Patient Name: _____ **Date of Birth:** _____

Family Physician: _____ **Medical Specialist:** _____

Are you under a physician's care now? O Yes O No Describe:

Have you ever been hospitalized or had a major operation? O Yes O No Describe:

Have you ever had a serious head or neck injury? O Yes O No Describe:

Are you taking any medications, pills, or drugs? O Yes O No List All Medications:

1.	2.	3.	4.
5.	6.	7.	8.

Do you regularly take herbal medicines or dietary supplements: O Yes O No

Circle all applicable: Garlic Ginko Ginseng Echinacea Ginger Kava Valerian Echinacea Feverfew Vitamin E St Johns wort

Do you use tobacco? O Yes O No

If yes, how interested are you in stopping your tobacco use? Check One ☐ Very Interested ☐ Somewhat Interested ☐ Not Interested

Women: Are you O Pregnant/Trying to get pregnant? Number of months pregnant _____ O Nursing?

Are you allergic to any of the following?

O Aspirin O Penicillin O Codeine O Acrylic O Metal O latex O local Anesthetics O Other _____

Do you have, or have had, any of the following? • condition may require premedication				
☐ AIDS/HIV Positive	☐ Cold Sores/Fever Blisters	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Shingles
☐ Alzheimer's Disease	☐ Congenital Heart Disorder*	☐ Heart Murmur	☐ Lung Disease	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions/ Seizures	☐ Heart Pace Maker	☐ Lupus	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Trouble/Disease*	☐ Mitral Valve Prolapse	☐ Spleen Removed
☐ Arthritis/Gout	☐ Diabetes TYPE I OR II	☐ Hemophilia	☐ Organ Transplant	☐ Steroid Therapy
☐ Artificial Heart Valve	☐ Easily Winded	☐ Hepatitis A	☐ Pain in Jaw Joints	☐ Stomach/Intestinal Disease
☐ Asthma	☐ Emphysema	☐ Hepatitis B or C	☐ Psychiatric care	☐ Stroke
☐ Blood Disease	☐ Epilepsy	☐ Herpes	☐ Radiation Treatments	☐ Subacute Bacterial Endocartis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ High Blood Pressure	☐ Recent Weight Loss	☐ Thyroid Disease
☐ Breathing Problem	☐ Excessive Thirst	☐ Hypoglycemia	☐ Renal Dialysis	☐ Tuberculosis
☐ Cancer	☐ Fainting Spells/Dizziness	☐ Kidney Problems	☐ Rheumatic Fever	☐ Tumors or Growths
☐ Chemotherapy	☐ Frequent Headaches	☐ Leukemia	☐ Rheumatic Heart Disease	☐ Ulcers
☐ Chest Palns	☐ Genital Herpes	☐ Liver Disease	☐ Rheumatoid Arthritis	☐ Venereal Disease

•Do you have any artificial joints? (If yes, answer questions below) O Yes O No Circle Type: Hip Knee Ankle Shoulder Other_____

a) How long have you had the prosthetic joint? (date of surgery) _____

b) Has it been replaced more than once? O Yes O No

c) Have you had any problems with the joint since it was replaced? O Yes O No

d) Is your immune system suppressed by disease, medications or treatments? O Yes O No

Have you ever received osteoporosis therapy? (examples are Fosamax. Actonel, Bonlva. Calciman O Yes O No

Have you ever had therapy to reduce high blood calcium (bisphosphonate therapy)? (examples: intravenous Aredia, Zometa) O Yes O No

Are you taking (or have you ever taken) **Xgeva** (Denosumab)? O Yes O No

a) If yes, did you ever have jaw pain, swelling, and numbness in the mouth, loose teeth or gum infections? O Yes O No

Are you or have you ever had a Drug/Alcohol addiction? O Yes O No

a) If yes, what kind? (ex: Alcohol, Prescription drugs, Heroin, Meth, Cocaine, Marijuana) Other _____

Have you ever had any serious illness not listed above? O Yes O No

How many sugared beverages do you drink per day? Week? _____

Comments

Dental History

Previous Family Dentist _____

Do you have any present dental concerns? ☐ Yes ☐ No

Describe _____

Date of last complete dental exam _____

Have you ever had orthodontic treatment? (braces) ☐ Yes ☐ No

Have you ever been treated for gum disease? ☐ Yes ☐ No

Do your gums bleed when you brush your teeth? ☐ Yes ☐ No

Do you grind or clinch your teeth? ☐ Yes ☐ No

Do you often have toothaches? ☐ Yes ☐ No

Do you have frequent sores in your mouth? ☐ Yes ☐ No

Have you had any injuries to your mouth or jaw? ☐ Yes ☐ No

If so, explain _____

Do you have any sores or swelling of your mouth or jaw? ☐ Yes ☐ No

Are you interested in saving your teeth? ☐ Yes ☐ No

Do you have any Dental implants? ☐ Yes ☐ No

Comments _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

X_____

Signature of patient, parent, or guardian

X_____

Date

X_____

Doctor's Signature