Health Questionnaire

The following questions are being asked for your health and safety. Please answer fully and accurately.

Please Use Blue or Black Ink.

Office Use Only

Yes No

Y N Are you in good health? **Age**____________ **Weight**____________ **Height**____________

Y N Are you under the care of a physician?
If so what is the condition being treated?____________

Y N Have you been hospitalized or had a serious illness or injury in the past five (5) years? If so, what?______

Y N Do you or have you ever had any of the following: (please circle all that apply)

Scarlet Fever	Sinus Problems	Psychiatric Problems
Rheumatic Fever	Porphyria	Anemia
Heart Murmur	Thyroid Condition/Goiter	Arthritis
Mitral Valve Prolapse	Epilepsy or Seizures	Drug Use/ Abuse
High Blood Pressure	Frequent/Severe headaches	Amphetamine Use
Stroke	Kidney Disease	Alcohol Abuse/ Use
Diabetes	Liver Disease	Asthma – Inhaler **Y** or **N** How often?______
Stomach Ulcers	Nervous Disorder	Other______

Y N Have you ever taken diet pills i. e. Phen-Phen?____________

Y N Have you ever taken a Bisphosphanate oral or I.V. (ex. Fossamax, Boniva, Actonel).

Y N Have you been taking any medications within the past year? (Including aspirin and birth control) please list______

Y N Are you now taking any of the following medications? Please circle: Antibiotics Nitroglycerin Insulin Cortisone Anticoagulants (Blood thinners) Blood Pressure medication Tranquilizers Digitalis Others______

Y N Are you Sensitive or Allergic to penicillin, aspirin, codeine, novocaine, xylocaine, or any other drugs or medicine?______

Y N Are you Allergic to Iodine, Eggs, Soy or Latex?

Y N Have you ever had or been exposed to hepatitis, herpes, AIDS, or venereal disease? (Confidential, will not effect your treatment)____________

Y N Have you ever had any lung disease or breathing difficulty? Emphysema, Tuberculosis, Pneumonia, other______

Y N Do you snore?

Y N Do you now or have you ever had any heart trouble? Heart Attack, Heart Failure, Coronary, Insufficiency, Angina, Unexplained chest pain, etc.____________

Y N Have you ever had a joint replacement, or heart valve replacement?____________

Y N Have you had any excessive bleeding requiring special treatment or blood transfusion? Explain:______

Y N Do you smoke? If yes, how many packs per day?______ For how long?______

Y N Do you have any neck or back pain? Explain: ____________

Y N Do you have difficulty opening your mouth wide? Explain:____________

Y N Does your jaw ever "click", pop, give you any pain, or have you had a TMJ treatment?______

Y N Have you ever received radiation or surgical treatment for a tumor, growth or other condition about your head, mouth, lips or any other portion of your body? Explain:____________

Y N Do you wear contact lenses?

Y N Do you have any disease, condition, or problem not listed above that you think we should know about? ______

Y N Have you ever been told to take **antibiotic premed** before dental treatments **for a heart or joint condition?**

Y N Is there a history of an **anesthesia** reaction in the family or yourself?

Y N **WOMEN:** Are you pregnant or trying to get pregnant at the present time? How many months? ____ **LMP**______

Y N If you are filling out this form for a minor, are you the parent or legal guardian?____________
Your Name

The above information is accurate to the best of my knowledge.

Signature________________________Date____________

(If minor, parent must sign)

Update________________________Date____________

Update________________________Date____________