NAME: _____ DATE OF BIRTH: _____
Please Print

E-mail address: _____Cell #_____

HEALTH QUESTIONNAIRE

Due to the ever increasing complexity of medical treatment and drug therapy, it is necessary for us to have a complete knowledge of your health status. This will help us avoid complications with any treatment or drug therapy that we may initiate. Your blood pressure will be taken at the minimum of once per year. Information disclosed on this form will be utilized solely for the purpose of your dental treatment in this office. We follow HIPPA Guidelines regarding your personal information.

Do you have any allergies? Please list: _____

Medications you are currently taking: _____

_____

Have you ever been told that you should take antibiotics before dental treatment? ……. YES NO

History of hospitalizations/outpatient treatment/surgeries _____

Are you currently being treated by a physician? (Physician's name & phone number) _____

Females: Are you currently taking birth control pills? …… YES NO
Are you or might you be pregnant? (Estimated due date)_____ …… YES NO
Are you breast feeding at the present time? …….. YES NO

HAVE YOU EVER HAD OR HAVE YOU NOW: (Please answer ALL questions)

Alcohol/drug addiction …….	YES	NO	HIV+ ……..	YES	NO
Anemia ……...	YES	NO	Kidney problems …….....	YES	NO
Arthritis ……	YES	NO	Liver disease ……	YES	NO
Asthma ……	YES	NO	Mitral valve prolapse ……..	YES	NO
Blood transfusion ……..	YES	NO	Pacemaker ……	YES	NO
Bruise or bleed easily ……...	YES	NO	Painful joints (including jaw) ...	YES	NO
Cancer / radiation treatment ……	YES	NO	Prosthetic heart valve(s) …….	YES	NO
Cold sores (Herpes) ……	YES	NO	Prosthetic joints ……	YES	NO
Congenital heart lesions ……..	YES	NO	Rheumatic fever ……..	YES	NO
Diabetes ……	YES	NO	Scarlet fever ……	YES	NO
Emphysema ……..	YES	NO	Sexually transmitted disease .	YES	NO
Epilepsy or Seizures …….	YES	NO	Should not donate blood …….	YES	NO
Gastric bypass surgery ……	YES	NO	Sickle cell disease ……	YES	NO
Glaucoma ……	YES	NO	Sinus problems ……..	YES	NO
Hay fever ……	YES	NO	Steroid medication ……	YES	NO
Heart murmur ……	YES	NO	Stroke ……	YES	NO
Heart problems or angina ……	YES	NO	Taken medication Fen-Phen ..	YES	NO
Heart surgery …….	YES	NO	Thyroid disease ……	YES	NO
Hemophilia (blood disorders) …….	YES	NO	Tuberculosis / PPD positive …	YES	NO
Hepatitis: Type _____ ……	YES	NO	Ulcers …….	YES	NO
High blood pressure ……	YES	NO	Unexplained weight change ...	YES	NO
Hives ……..	YES	NO	Yellow jaundice ……	YES	NO

Do you have a disease, condition or problem not listed above? _____

Doctors Comments: _____

Signature: _____ Date: _____ BP: _____

Signature: _____ Updated: _____ BP: _____

Signature: _____ Updated: _____ BP: _____

Signature: _____ Updated: _____ BP: _____