

# DENTAL HEALTH QUESTIONNAIRE

Patient name \_\_\_\_\_ Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

My reason for this Examination is: \_\_\_\_\_

1. Yes No....Are you in good health? Date of last medical exam: \_\_\_\_\_ Date of last Dental Appt: \_\_\_\_\_
2. Yes No....Has there been a change in your health within the last year?
3. Yes No....Have you been hospitalized or had a serious illness or operation?  
If so, why? \_\_\_\_\_
4. Yes No....Are you being treated by a physician now? If so, for what? \_\_\_\_\_
5. Yes No....Are you taking any medicine? (Including Aspirin) if so, please list \_\_\_\_\_
6. Yes No....Are you sensitive or allergic to any drug? If so, what? \_\_\_\_\_
7. Yes No....are you allergic to latex?
7. Yes No....Have you ever been pre-medicated with antibiotics for dental treatment?
8. Yes No....Have you taken the diet medication/Fen-Phen in the past?
9. Yes No.... Are you currently taking osteoporosis medications/ Fosomax?

**Please check box by any condition you previously or now have.**

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Epilepsy or seizures  | <input type="checkbox"/> Anemia                   | <input type="checkbox"/> Prosthetic heart valve | <input type="checkbox"/> HIV+/AIDS                 |
| <input type="checkbox"/> Fainting or dizziness | <input type="checkbox"/> Sickle cell deficiency   | <input type="checkbox"/> Pacemaker              | <input type="checkbox"/> Arthritis                 |
| <input type="checkbox"/> Nervousness           | <input type="checkbox"/> G-6PD deficiency         | <input type="checkbox"/> Blood transfusion      | <input type="checkbox"/> Painful joints (incl.jaw) |
| <input type="checkbox"/> Stroke                | <input type="checkbox"/> Hemophilia               | <input type="checkbox"/> Liver disease          | <input type="checkbox"/> Prosthetic joints         |
| <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Bruise or Bleed easily   | <input type="checkbox"/> Yellow jaundice        | <input type="checkbox"/> Hives                     |
| <input type="checkbox"/> Cold sores (Herpes)   | <input type="checkbox"/> Heart problems or angina | <input type="checkbox"/> Hepatitis type: _____  | <input type="checkbox"/> Steroid medication(s)     |
| <input type="checkbox"/> Persistent cough      | <input type="checkbox"/> Hypertension             | <input type="checkbox"/> Ulcers                 | <input type="checkbox"/> Drug addiction            |
| <input type="checkbox"/> Emphysema             | <input type="checkbox"/> Rheumatic fever          | <input type="checkbox"/> Kidney problems        | <input type="checkbox"/> Alcoholism                |
| <input type="checkbox"/> Tuberculosis/PPD+     | <input type="checkbox"/> Heart murmur             | <input type="checkbox"/> Venereal Disease       | <input type="checkbox"/> Unexplained weight change |
| <input type="checkbox"/> Asthma                | <input type="checkbox"/> Mitral valve Prolapse    | <input type="checkbox"/> Thyroid Disease        | <input type="checkbox"/> Cancer/ Chemo therapy     |
| <input type="checkbox"/> Hay fever             | <input type="checkbox"/> Congenital heart disease | <input type="checkbox"/> Skin diseases          | <input type="checkbox"/> Radiation therapy         |
| <input type="checkbox"/> Sinus problems        | <input type="checkbox"/> Heart surgery            | <input type="checkbox"/> Dry mouth              | <input type="checkbox"/> Psychiatric problems      |
| <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Headaches/Migraines    |  |

9. Yes No....Do you have any disease, condition or problem not listed that you think I should know about?  
If so, what? \_\_\_\_\_

**10. Women Only:**

- a. Yes No....Are you taking Birth control pills?
- b. Yes No....Are you or might you be pregnant? Estimated delivery date \_\_\_\_\_
- c. Yes No....Are you breast feeding at the present time?

**11. Social History:**

- a. Yes No....Do you smoke? If so, how much? \_\_\_\_\_
- b. Yes No....Do you drink alcoholic beverages? If so, how much? \_\_\_\_\_
- c. Yes No....Do you have a family history of:  Diabetes  Cancer  Heart disease?

**12. Dental History:**

- a. Yes No....Are you currently in pain?
- b. Yes No....Have you ever had an unfavorable reaction from local anesthetic?
- c. Yes No....Are you happy with the appearance of your teeth?
- d. Yes No....Have you had any abnormal bleeding after a cut or extraction?
- e. Yes No....Have you ever been treated for periodontal disease?
- f. Yes No....Do your gums bleed easily or after brushing or flossing?
- g. Yes No....Have you had problems with prior dental treatment? If so, explain \_\_\_\_\_
- h. Yes No....Does dental treatment make you nervous?
- i. Yes No....Would you desire to be sedated?

*To the best of my knowledge, I have answered every question completely and accurately, I will inform my dentist of any change in my health and/or medication.*

Patient's signature \_\_\_\_\_ Date \_\_\_\_\_ Doctor's signature \_\_\_\_\_ date \_\_\_\_\_

**Health History Updates:**

Patient's signature \_\_\_\_\_ Date \_\_\_\_\_ Patient's signature \_\_\_\_\_ date \_\_\_\_\_

Patient's signature \_\_\_\_\_ Date \_\_\_\_\_ Patient's signature \_\_\_\_\_ date \_\_\_\_\_