

# HEALTH QUESTIONNAIRE

Name \_\_\_\_\_ Birth date \_\_\_\_\_

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Circle yes or no, whichever applies, in response to the following questions. Your answers are for our records only and will be considered confidential.

## DENTAL

- Are you having any discomfort at this time ..... Yes No
- Have you ever had any serious trouble associated with previous dental treatment? ..... Yes No  
If so explain? \_\_\_\_\_
- Does dental treatment make you nervous? No \_\_\_\_\_ Slightly \_\_\_\_\_ Moderately \_\_\_\_\_ Extremely \_\_\_\_\_
- Date of last dental visit \_\_\_\_\_
- Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? ..... Yes No  
If so when? \_\_\_\_\_
- How often do you brush \_\_\_\_\_  
Brush is: Soft  Medium  Hard
- Do you have or have you ever had any of the following?

### MOUTH

- |   |     |    |
|---|-----|----|
| Bleeding, sore gums .....               | Yes | No |
| Unpleasant taste/bad breath .....       | Yes | No |
| Burning tongue/lips .....               | Yes | No |
| Frequent blisters, lip/mouth .....      | Yes | No |
| Swelling/lumps in mouth .....           | Yes | No |
| Ortho treatments (braces) .....         | Yes | No |
| Biting cheeks/lips .....                | Yes | No |
| Clicking/popping jaw .....              | Yes | No |
| Difficulty opening or closing jaw ..... | Yes | No |

### TEETH

- |                           |     |    |
|---------------------------|-----|----|
| Loose teeth .....         | Yes | No |
| Sensitive to hot .....    | Yes | No |
| Sensitive to cold .....   | Yes | No |
| Sensitive to sweets ..... | Yes | No |
| Sensitive to biting ..... | Yes | No |
| Food impaction .....      | Yes | No |
| Clenching/grinding .....  | Yes | No |
| If so, when _____         |     |    |
| Shifting in bite .....    | Yes | No |
| Change in bite .....      | Yes | No |

- Do you use the following?  
Brush ..... Yes No  
Dental floss ..... Yes No  
Fluoride rinse ..... Yes No  
Other \_\_\_\_\_

## MEDICAL

- Has there been any change in your general health within the past year ..... Yes No
- My last physical examination was on \_\_\_\_\_
- Are you now under the care of a physician ..... Yes No  
If so, what is the condition being treated \_\_\_\_\_
- The name and address of my physician is \_\_\_\_\_
- Have you had any serious illness within the past five (5) years ..... Yes No  
If so, what was the illness \_\_\_\_\_
- Have you been hospitalized or had an operation within the past five (5) years ..... Yes No  
If so, what was the problem \_\_\_\_\_
- Do you have or have you had any of the following diseases or problems  
a. Rheumatic fever or rheumatic heart disease ..... Yes No  
b. Congenital heart disease ..... Yes No  
c. Cardiovascular disease (heart trouble, heart attack, heart murmur, coronary insufficiency, coronary occlusion, high/low blood pressure, arteriosclerosis, stroke, etc.) ..... Yes No  
1) Do you have pain in chest upon exertion ..... Yes No  
2) Are you ever short of breath after mild exercise ..... Yes No  
3) Do your ankles swell ..... Yes No  
4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep ..... Yes No  
d. Artificial or replacement valves ..... Yes No  
e. Pacemaker ..... Yes No  
f. Allergy ..... Yes No  
g. Sinus trouble ..... Yes No  
h. Asthma or hay fever ..... Yes No  
i. Hives or a skin rash ..... Yes No  
j. Fainting spells or seizures ..... Yes No  
k. Diabetes ..... Yes No  
1) Do you have to urinate (pass water) more than six times a day ..... Yes No  
2) Are you thirsty much of the time ..... Yes No  
3) Does your mouth frequently become dry ..... Yes No



- l. Hepatitis, jaundice or liver disease ..... Yes No
- m. Arthritis or inflammatory rheumatism ..... Yes No
- n. Artificial or replacement joints, prosthetic ..... Yes No
- o. Digestive system—Ulcers or stomach disorders (colitis) ..... Yes No
- p. Kidney trouble ..... Yes No
- q. Tuberculosis ..... Yes No
- r. Persistent cough or cough up blood ..... Yes No
- s. Immune System disorders (including AIDS, HIV, ARC) ..... Yes No
- t. Venereal disease ..... Yes No
- u. Other \_\_\_\_\_
- 8. Have you had abnormal bleeding associated with previous extractions, surgery or trauma? ..... Yes No
  - a. Do you bruise easily ..... Yes No
  - b. Have you ever required a blood transfusion ..... Yes No
    - If so, explain the circumstances & when \_\_\_\_\_
- 9. Have you ever tested positive for the AIDS virus? ..... Yes No
- 10. Do you have any blood disorder such as anemia? ..... Yes No
- 11. Have you had surgery or x-ray treatment for a tumor, growth, or other condition? ..... Yes No
- 12. Are you taking any of the following:
  - a. Antibiotics or sulfa drugs ..... Yes No
  - b. Anticoagulants (blood thinners) ..... Yes No
  - c. Medicine for high blood pressure ..... Yes No
  - d. Cortisone (steroids) ..... Yes No
  - e. Tranquilizers ..... Yes No
  - f. Antihistamines ..... Yes No
  - g. Aspirin ..... Yes No
  - h. Insulin, tolbutamide (Orinase) or similar drug for diabetes ..... Yes No
  - i. Digitalis or drugs for heart trouble ..... Yes No
  - j. Nitroglycerin ..... Yes No
  - k. Other medications ..... Yes No
  - l. If "Yes" to any of the above, state drug name, dosage and frequency \_\_\_\_\_
- 13. Are you allergic or have you reacted adversely to:
  - a. Local anesthetics ..... Yes No
  - b. Penicillin or other antibiotics ..... Yes No
  - c. Sulfa drugs ..... Yes No
  - d. Barbiturates, sedatives, or sleeping pills ..... Yes No
  - e. Aspirin ..... Yes No
  - f. Iodine ..... Yes No
  - g. Codeine or other narcotics ..... Yes No
  - h. Other \_\_\_\_\_
- 14. Do you use any tobacco products ..... Yes No
  - If so, how much per day and what \_\_\_\_\_
- 15. Do you use any alcohol products ..... Yes No
  - If so, how much per day/week/month and what \_\_\_\_\_
- 16. Do you use any caffeinated products (coffee, tea, chocolate, etc.) ..... Yes No
  - If so, how much per day and what \_\_\_\_\_
- 17. Do you have any disease, condition, or problem not listed above that you think I should know about? ..... Yes No
  - If so, explain \_\_\_\_\_
- 18. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation ..... Yes No
- 19. Are you wearing contact lenses ..... Yes No
- 20. Are you experiencing stress or pressure in your work or at home ..... Yes No

**WOMEN**

- 20. Are you pregnant ..... Yes No
- 21. Do you have PMS or problems associated with your menstrual period ..... Yes No
- 22. Are you taking birth control or hormone therapy ..... Yes No

Remarks:

*To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.*