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Health History Questionnaire

1. How do you rate your current physical health?... Good Fair Poor
2. Have there been any changes in your general health in the past year?......... Yes No
   (If yes, please explain)____
   ____
   ____
3. What is the approximate date of your last doctor's visit?_____________
4. Do you have a physician or family doctor?.. Yes No
   (Name, address and phone number)_____________________________
   ____
5. Have you been hospitalized for any surgical operation or serious illness within the last 5 years? (Please explain).. Yes No
   ____
   ____
6. Are you taking any medication(s) including non-prescription medicine?.... Yes No
   (Please list)____
   ____
   ____
7. Are you allergic to, had any reactions to, or been advised not to take any of the following?... Yes No
   - ☐ Dental anesthetic injections
   - ☐ Sedatives
   - ☐ Penicillin
   - ☐ Erythromycin
   - ☐ Clindamycin
   - ☐ Tetracycline
   - ☐ Codeine
   - ☐ Aspirin
   - ☐ Tylenol
   - ☐ Sulfa drugs
   - ☐ Barbiturates
   - ☐ Iodine
   - ☐ Any metals (e.g. nickel, mercury, etc.)
   - ☐ Latex rubber
   - ☐ Nitrile rubber
   - ☐ NSAIDs (Advil, Naprosyn)
   - ☐ Other:_______________

Cardiovascular Health:

8. Have you ever had any of the following:..................................Yes When_______ No
   - ☐ Artificial heart valve or repair
   - ☐ History of Endocarditis
   - ☐ Heart Transplant
   - ☐ Congenital Heart Disease
   - ☐ Heart Attack
   - ☐ Stents
   - ☐ Congenital Heart Defect / Artificial Repair
   - ☐ Congenital Heart Defect / Residual Defect

9. Do you have any of the following:.. Yes No

- ☐ Rheumatic heart disease/ Heart Murmur
- ☐ Shortness of Breath after Mild activity
- ☐ Chest pain after Activity
- ☐ Swollen Ankles
- ☐ Need for extra pillows to sleep
- ☐ Cardiac Pacemaker or Defibrillator
- ☐ High Blood Pressure
- ☐ Low Blood Pressure

Central Nervous System :

10. Do you have or have you had any of the following:... Yes No

- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ Seizures
- ☐ Emotional Disturbance

Respiratory System:

11. Do you have or have you had any of the following:... Yes No

- ☐ Emphysema, Chronic Bronchitis, Asthma
- ☐ Sinus Trouble
- ☐ Persistent Cough or Cold
- ☐ Tuberculosis
- ☐ Family History of Tuberculosis

GI Tract:

12. Do you have or have you had any of the following:... Yes No

- ☐ Acid Reflux or GERD
- ☐ Hepatitis A, B, C, Autoimmune
- ☐ Jaundice
- ☐ Liver Disease
- ☐ Bloody Vomit or Diarrhea

Endocrine System:

13. Do you have any of the following:.. Yes No

- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Hypothyroidism
- ☐ Hyperthyroidism

14. Do you have the urge to urinate more than 6 times in a day?.......................... Yes No

15. Do you constantly feel thirsty or feel like you have dry mouth?...................... Yes No

Hematogenic System:

16. Do you have or have you had any of the following:... Yes No

- ☐ Anemia
- ☐ Sickle Cell Disease
- ☐ Hemophilia
- ☐ Blood Transfusion
- ☐ HIV / AIDS
- ☐ Any Immunodeficiency
- ☐ Any Abnormal Bleeding after Surgery or Trauma

Genitourinary System:

17. Do you have or have you ever had any of the following:.................................. Yes No

- ☐ Kidney Trouble
- ☐ Dialysis
- ☐ Syphilis or Gonorrhea

Skeletal System:

18. Do you have or have you ever had any of the following:..............Yes When_____ No

- ☐ Arthritis
- ☐ Inflammatory rheumatism
- ☐ Bone Infection
- ☐ Osteoporosis
- ☐ Artificial Joint Replacement Which_____

19. Have you received or are you currently taking any Bisphophonates? ....Yes No

- ☐ Zometa
- ☐ Aridia
- ☐ Fosamax
- ☐ Actonal
- ☐ Boniva
- ☐ Prolia
- ☐ Other______

20. Do you have or have you had any tumor or malignancy?.............. Yes When_____ No
21. Have you undergone any Chemotherapy or Radiation Therapy?... Yes When_____No
22. Do you have Glaucoma?.. Yes No
23. Do you smoke or use tobacco?.. Yes No

    Type:_____________ Amount of Daily use:_______________
24. Do you use controlled substances?.. Yes No
25. Have you ever taken prescription diet pills?... Yes No
    - ☐ Fen-Phen (Fenfluramine-Phentermine)
    - ☐ Pondimen (Fenfluramine)
    - ☐ Redux (Dexfenfluramine)
    - ☐ Other:_______________
26. Do you have any other condition that may not have been mentioned that you do or do not believe we need to know about (Please explain)?................ Yes No

    ____

    ____
27. What is the reason for your visit today?___________________________
28. When was the last time you were seen by a dentist?__________________
29. How nervous are you when it comes to Dental treatment?

    Not at all   Slightly   Moderately   Extremely

Women only:

Please select all that apply to you.

- ☐ Pregnant or think you may be pregnant Weeks:_________
- ☐ Nursing
- ☐ Taking oral contraceptives (birth control pills)
- ☐ None of the above

Patients with a medical history or symptoms indicative of an undiagnosed active disease will be promptly referred to their physician and deferred from office/treatment until their physician confirms that the patient does not have a communicable disease or is no longer infectious. I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such medical care to third payors and/or health practitioners. I authorize and request my insurance company to pay directly to the doctor or doctor group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature:_________________________________ Date:_________