Health Questionnaire

____/____/_____ _____ ____/____/_____

Today's Date Patient's Name Birthdate

- MEDICATIONS you are taking: provide list or write in spaces below (dosage not necessary):

_____ _____ _____

_____ _____ _____

_____ _____ _____

- Do you take a BLOOD THINNER / ANTICOAGULANT Y N
- MEDICATION ALLERGIES or any medications you have been told to avoid:

_____

- Do you have a HISTORY OF DISEASE/SURGERY/DISORDER of: (CIRCLE ALL THAT APPLY)

HEART	THYROID	OSTEOPOROSIS	HIGH BLOOD PRESSURE
LUNGS	DIABETES	JOINT REPLACEMENT	RADIATION THERAPY
LIVER	CANCER	NERVOUS SYSTEM	(IN HEAD/NECK AREA ONLY)
KIDNEYS	BLOOD	IMMUNE SYSTEM	OTHER

EXPLANATIONS:_____

_____

_____

ARE YOU ALLERGIC TO LATEX? Y N

Have you been told you have TMJ/TMD? Y N

Do you grind your teeth? Y N

Have you been told you have gum disease? Y N

Have you had orthodontics/braces? Y N

Do you wear a denture or partial? Y N

Do you wish to talk to the doctor or staff about Invisalign, cosmetic dentistry, or teeth whitening treatments? Y N

Females: Are you or could you be pregnant? Y N

(DUE DATE)_____

Do you smoke? Y N

Do you use smokeless tobacco? Y N

On back teeth do you prefer:

____ white/composite fillings for improved appearance

____ silver/amalgam fillings for improved durability

____I would like the doctor to choose based on his professional judgment

List any concerns/requests: _____

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.

_____ _____

Date Signature

FUTURE USE: I have reviewed my health history and listed any changes above:

Date:_____Initials:_____ Date:_____Initials:_____

Date:_____Initials:_____ Date:_____Initials:_____