HEALTH QUESTIONNAIRE

Patient's Name ______________________________

Medical History

Physician: ________________________________ ________________________ ______________________

Name Telephone Number City

Have you been under the care of a physician in the last five years? [ ] YES [ ] NO

If yes, please explain____

Have you been hospitalized within the last five years? [ ] YES [ ] NO

If yes, please explain ____

Please respond YES if you have ever had, or NO if you have never had any of the following:

YES	NO		YES	NO		YES	NO	
[ ]	[ ]	Rheumatic fever	[ ]	[ ]	Latex Allergy	[ ]	[ ]	Thyroid disease
[ ]	[ ]	Heart murmur	[ ]	[ ]	Chemotherapy/Radiation	[ ]	[ ]	Kidney disease
[ ]	[ ]	Prosthetic heart valve	[ ]	[ ]	Ulcer/Colitis	[ ]	[ ]	Stroke
[ ]	[ ]	Mitral valve prolapse	[ ]	[ ]	High blood pressure	[ ]	[ ]	Arthritis
[ ]	[ ]	Bacterial endocarditis	[ ]	[ ]	Low blood pressure	[ ]	[ ]	Tumor
[ ]	[ ]	Joint replacement	[ ]	[ ]	Blood disease	[ ]	[ ]	Liver disease
[ ]	[ ]	Artificial Prothesis	[ ]	[ ]	Blood transfusion	[ ]	[ ]	Hepatitis/Jaundice
[ ]	[ ]	Pacemaker	[ ]	[ ]	Diabetes	[ ]	[ ]	HIV positive/AIDS
[ ]	[ ]	Excessive bleeding	[ ]	[ ]	Loss of consciousness	[ ]	[ ]	Venereal disease
			[ ]	[ ]	Seizure	[ ]	[ ]	Glaucoma
			[ ]	[ ]	Sinus trouble	[ ]	[ ]	Nervous disorder

Are you taking any medications? (including birth control pills) [ ] YES [ ] NO

If yes, what ____

Are you allergic to: [ ] Penicillin [ ] Codeine [ ] Novocaine [ ] Other [ ] None

If other, what ____

Are you pregnant? [ ] YES [ ] NO If yes, how many months? ______________________________

Is there any other information that should be known about your health? ______________________________

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Dental History

What is the reason for your dental visit? ____

Date of last X-rays ______________________________ Date of last cleaning ______________________

Name of previous dentist ______________________________ Reason for leaving ______________

Do your gums bleed? [ ] YES [ ] NO

Are any of your teeth sensitive to: [ ] Heat [ ] Cold [ ] Sweet

Do you have pain or popping in or near your ears? [ ] YES [ ] NO

Is there any other information you would like us to know to make your visit more comfortable? ____________

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I hereby declare that the information above is accurate and complete to the best of my knowledge. If I have any changes in my health, or if my medications change, I will inform the doctor at the next visit before treatment is rendered.

____ ______________________

Signature of Patient/Parent/Guardian Date