HEALTH QUESTIONNAIRE

Please fill out your dental and medical histories to the best of your ability.

***This information is confidential!***

**DENTAL HISTORY**

Reason for today’s visit: Date of last dental visit:

Treatment done at last visit: Date of last X-rays:

Your dentist(s): Phone: ( )

Are you anxious/nervous about receiving dental treatment? 🞎Yes 🞎No 🞎Somewhat

Have you had a bad experience with dental treatment? 🞎Yes 🞎No

Are you happy with your smile? 🞎Yes 🞎No 🞎Somewhat

Check all the problems you have: 🞎 I have none of these

🞎 Bleeding gums 🞎 Bad breath 🞎 Hot/cold sensitivity 🞎 Sweet sensitivity

🞎 Food gets stuck between teeth 🞎 Dry mouth 🞎 Earaches 🞎 Clicking/popping jaw

🞎 Grind/clench teeth 🞎 Sores in mouth 🞎 Wear partials/dentures 🞎 Uncomfortable bite

🞎 Bad fillings/crowns/dentures 🞎 Ugly fillings/crowns/dentures 🞎 Dentures/partials don’t fit well 🞎 Swelling

🞎 Stained/yellow teeth 🞎 Spaces between teeth 🞎 Crowded/overlapped teeth 🞎 Had braces/retainers

🞎 Pain/ache 🞎 Other

**MEDICAL HISTORY**

Your physician’s name: Date of last visit:

Reason for last visit: Physician’s phone: ( )

Do you see a physician regularly? 🞎Yes 🞎No If yes, for what?

Have you ever had any serious illness or operation? 🞎Yes 🞎No Have you ever been hospitalized? 🞎Yes 🞎No

If yes, describe (incl. date):

Have you ever had blood transfusions? 🞎Yes 🞎No Reason: Approximate date:

Women: Are you pregnant? 🞎Yes 🞎No 🞎Possibly Take birth control pills? 🞎Yes 🞎No Nursing? 🞎Yes 🞎No

Are you taking or have you ever taken: 🞎 “fen-phen” 🞎 Steroids 🞎 Recreational drugs 🞎 Bisphosphonates

 🞎 Fosamax (Alendronate) 🞎 Actonel (Risedronate) 🞎 Aredia 🞎 Zometa

Check all problems/treatments you have or have had:

🞎Yes 🞎No **Anemia** 🞎Yes 🞎No **Diabetes** 🞎Yes 🞎No **Jaw pain** 🞎Yes 🞎No **Sinus trouble**
🞎Yes 🞎No **Arthritis, Rheumatism** 🞎Yes 🞎No **Epilepsy** 🞎Yes 🞎No **Kidney Disease** 🞎Yes 🞎No **Skin rash**

🞎Yes 🞎No **Artificial Heart Valves** 🞎Yes 🞎No **Fainting/dizziness** 🞎Yes 🞎No **Liver Disease** 🞎Yes 🞎No **Special diet**

🞎Yes 🞎No **Artificial Joints** 🞎Yes 🞎No **Gastric Bypass** 🞎Yes 🞎No **Mitral Valve Prolapse** 🞎Yes 🞎No **Stomach Ulcer**

🞎Yes 🞎No **Asthma** 🞎Yes 🞎No **Glaucoma** 🞎Yes 🞎No **Osteoporosis**  🞎Yes 🞎No **Intestinal Ulcer**

🞎Yes 🞎No **Back problems** 🞎Yes 🞎No **Headaches**  🞎Yes 🞎No **Pacemaker**  🞎Yes 🞎No **Stroke**

🞎Yes 🞎No **Bleeding problems** 🞎Yes 🞎No **Heart murmur**  🞎Yes 🞎No **Panic/anxiety**  🞎Yes 🞎No **Thyroid Problems**

🞎Yes 🞎No **Blood disease** 🞎Yes 🞎No **Heart problems** 🞎Yes 🞎No **Tobacco/smoking** 🞎Yes 🞎No **Tonsillitis**

🞎Yes 🞎No **Cancer** 🞎Yes 🞎No **Hemophilia** 🞎Yes 🞎No **Psychiatric care** 🞎Yes 🞎No **Tuberculosis**

🞎Yes 🞎No **Chemical dependency** 🞎Yes 🞎No **Hepatitis** 🞎Yes 🞎No **Radiation treatment** 🞎Yes 🞎No **Tumor/growth** 🞎Yes 🞎No **Chemotherapy** 🞎Yes 🞎No **Herpes** 🞎Yes 🞎No **Respiratory disease**

🞎Yes 🞎No **Circulatory problems** 🞎Yes 🞎No **High blood pressure** 🞎Yes 🞎No **Scarlet fever**

🞎Yes 🞎No **Cortisone treatments** 🞎Yes 🞎No **HIV/AIDS**  🞎Yes 🞎No **Shortness of breath**

🞎Yes 🞎No **Cough blood** 🞎Yes 🞎No **Rheumatic fever**

🞎 Other, please describe:

List all prescription medications you are taking:

List all over-the-counter medications and nutritional supplements you are taking:

List all allergies you have:

The information on this form is true and correct as of the date indicated below to the best of my knowledge. I understand that not reporting any conditions/medications/allergies may complicate my treatment, and may pose a serious health risk to me, and to the healthcare team.

Patient’s Name Signature (guardian, if patient under 18) Date

Medical History Reviewed Date

 **MEDICAL HISTORY UPDATE FORM Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Has there been any change in your health since your last dental appointment? 🞎Yes 🞎No

If yes, for what?

Are you taking any kind of medications at this time? 🞎Yes 🞎No 🞎No Change Since Last Visit

If there are changes, please list

 \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Patient Signature Doctor Signature

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