HEALTH QUESTIONAIRE

NAME OF PHYSICIAN _____ CITY _____ DATE OF LAST PHYSICAL _____

PLEASE "X" EACH BOX IF THE ANSWER IS "YES", LEAVE BLANK IF "NO"
HAVE YOU HAD . . .

- ❒ HEART PROBLEMS
- ❒ HIGH BLOOD PRESSURE
- ❒ LOW BLOOD PRESSURE
- ❒ CIRCULATORY PROBLEMS
- ❒ RHEUMATIC FEVER
- ❒ HEPATITIS
- ❒ DIABETES
- ❒ RADIATION TREATMENTS
- ❒ EPILEPSY
- ❒ KIDNEY PROBLEMS
- ❒ NERVOUS PROBLEMS
- ❒ TUBERCULOSIS
- ❒ EXCESSIVE BLEEDING
- ❒ CEREBAL PALSY
- ❒ SCARLET FEVER
- ❒ MALIGNANCIES
- ❒ CHRONIC SINUS
- ❒ CHRONIC EAR PROBLEMS
- ❒ ANEMIA
- ❒ ARTHRITIS
- ❒ ADENOIDS REMOVED
- ❒ TONSILS REMOVED
- ❒ ASTHMA
- ❒ VENEREAL DISEASE/HERPES

OTHER HEALTH COMPLICATIONS: _____

HAVE YOU EVER TESTED POSITIVE FOR HTLV III (AIDS)? YES _____ NO_____

DO YOU USE TOBACCO PRODUCTS? YES _____ NO_____

ARE YOU ALLERGIC TO:

❒ PENICILLIN ❒ ASPIRIN ❒ CODEINE ❒ LOCAL ANESTHETICS (i.e. Novacaine)

❒ OTHER: _____

ARE YOU PREGNANT? _____ IF YES, HOW MANY MONTHS? _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: _____

_____

PLEASE LIST ANY OTHER MEDICAL CONDITIONS YOU FEEL THE DOCTOR SHOULD BE AWARE OF _____

_____

DENTAL HEALTH INFORMATION

NAME OF PREVIOUS DENTIST _____ CITY _____ DATE OF LAST VISIT _____

ARE YOU SENSITIVE TO:

❒ HEAT ❒ COLD ❒ SWEETS ❒ CHEWING

HAVE YOU HAD ANY INJURIES TO THE MOUTH / JAW AREA? _____

IF YES, PLEASE EXPLAIN: _____

CHECK UP APPOINTMENTS

WHEN WAS YOUR LAST CHECK-UP AND CLEANING?: _____

FOR ALL PATIENTS

PLEASE LIST ANY PREVIOUS EXPERIENCES OR PROBLEMS YOU WOULD LIKE THE DOCTOR TO BE AWARE OF: _____

_____

SIGNATURE OF RESPONSIBLE PARTY _____ RELATIONSHIP _____ DATE _____

S.I. (1) _____ S.I. (2) _____

_____