CHRIS J DUMAS DDS, PC
COMPREHENSIVE AND COSMETIC DENTISTRY

6900 E. Belleview Ave. #203 | Greenwood Village, CO 80111
303-796-8668 | FAX 303-804-5629 | info@drdumas.com

HEALTH QUESTIONNAIRE

All information is confidential.

Patient's Name ______________________ Date of Birth ____________

Today's Date ____________

Do you have or have you ever had the following:	YES	NO
High or Low Blood Pressure	☐	☐
Heart Disease or Heart Attack	☐	☐
Heart Murmur	☐	☐
Angina or Chest Pain	☐	☐
Stroke	☐	☐
Circulatory Problems	☐	☐
Bleeding Problems	☐	☐
Cancer	☐	☐
Benign Tumors	☐	☐
Diabetes	☐	☐
Ulcers, Intestianl Disorders	☐	☐
Eating Disorders	☐	☐
Hepatitis, Jundice, Liver Disease	☐	☐
Seizures	☐	☐
Arthritis, Joint Disease	☐	☐
Artifical Joints, Implants	☐	☐
Chronic Neck or Back Pain	☐	☐
Tuberculosis	☐	☐
Asthma	☐	☐
Blood Transfusions	☐	☐
AIDS or HIV+	☐	☐
Sexually Transmitted Diseases	☐	☐
Alcohol/Substance Abuse	☐	☐
Women – Pregnant (if yes, _____ months)	☐	☐
Other Medical Concerns ______________________		
Headache, Migraines, Cluster Headaches	☐	☐

Cold Sores, Fever Blisters	☐	☐
Slow Healing Sores on Mouth or Lips	☐	☐
Jaw that Click, Lock or Pop	☐	☐
Face, Neck or Ear Pain	☐	☐
Restless, Interrupted Sleep	☐	☐
Dry Mouth	☐	☐
Loose or Sensitive Teeth	☐	☐
Sore or Bleeding Gums	☐	☐
Do you Clench or Grind Teeth	☐	☐
Do you Vape, Smoke or Chew Tobacco (if so, how much ____________).	☐	☐
Do you use any controlled substances (drugs) for recreational purposes	☐	☐
Do you like your smile	☐	☐

Date of last dental visit ______________________________

Are you allergic to or had unsual reactions to any of the following:

Local Anesthesia	☐	☐
Any Metals - List ______________________________	☐	☐
Any Dental Care - Describe ______________________________	☐	☐
Penicillin	☐	☐
Aspirin	☐	☐
Codeine/Narcotics	☐	☐
Latex	☐	☐
Any Other Drugs - List ______________________________	☐	☐

Please list any serious illness or operations and date ______________________________

____

Please list all medications you are taking and their purpose ______________________________

____

Please describe your general health: ______________________________

____

I am seeking dental care because: ______________________________

I, the undersigned, believe the above information is complete and correct. I understand that risks are involved in routine dental procedures and in the use of local anesthetics. These risks include but are not limited to allergy, bleeding, infection and paraesthesia (prolonged numbness). I consent to examination, necessary radiographs, and routine treatment knowing that no treatment will be begun without my permission. I understand that I may ask any questions at any time.

____

Signature of Patient or person authorized to consent for patient Date

History Updates

____

____

____

____