

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	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease or Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Angina or Chest Pain.	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory Problems	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Benign Tumors	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers, Intestianl Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Eating Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis, Jundice, Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Seizures.	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis, Joint Disease.	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints, Implants.	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Neck or Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusions	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV+.	<input type="checkbox"/>	<input type="checkbox"/>
Sexually Transmitted Diseases	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol/Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>
Women – Pregnant (if yes, _____ months)	<input type="checkbox"/>	<input type="checkbox"/>
Other Medical Concerns _____		
Headache, Migraines, Cluster Headaches	<input type="checkbox"/>	<input type="checkbox"/>

Cold Sores, Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>
Slow Healing Sores on Mouth or Lips	<input type="checkbox"/>	<input type="checkbox"/>
Jaw that Click, Lock or Pop	<input type="checkbox"/>	<input type="checkbox"/>
Face, Neck or Ear Pain	<input type="checkbox"/>	<input type="checkbox"/>
Restless, Interrupted Sleep	<input type="checkbox"/>	<input type="checkbox"/>
Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>
Loose or Sensitive Teeth	<input type="checkbox"/>	<input type="checkbox"/>
Sore or Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>
Do you Clench or Grind Teeth	<input type="checkbox"/>	<input type="checkbox"/>
Do you Vape, Smoke or Chew Tobacco (if so, how much _____)	<input type="checkbox"/>	<input type="checkbox"/>
Do you use any controlled substances (drugs) for recreational purposes	<input type="checkbox"/>	<input type="checkbox"/>
Do you like your smile	<input type="checkbox"/>	<input type="checkbox"/>
Date of last dental visit _____		

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

Local Anesthesia	<input type="checkbox"/>	<input type="checkbox"/>
Any Metals - List _____	<input type="checkbox"/>	<input type="checkbox"/>
Any Dental Care - Describe _____	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Codeine/Narcotics	<input type="checkbox"/>	<input type="checkbox"/>
Latex	<input type="checkbox"/>	<input type="checkbox"/>
Any Other Drugs - List _____	<input type="checkbox"/>	<input type="checkbox"/>

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
