HEALTH QUESTIONNAIRE FOR DENTAL TREATMENT

Name: _____ Date: _____

Physician: _____ Physician Phone: _____

Heart Trouble.....Yes / No
Heart Murmur.....Yes / No
Pacemaker.....Yes / No
High Blood Pressure.....Yes / No
Low Blood Pressure.....Yes / No
Stroke .....Yes / No
Thyroid Disease.....Yes / No
Kidney Disease.....Yes / No
Liver Disease.....Yes / No
Hepatitis.....Yes / No
Cancer.....Yes / No
Autoimmune Disorder.....Yes / No
Prosthetic Joint.....Yes / No
Pulmonary Disease.....Yes / No
Tuberculosis.....Yes / No

Sinus Trouble.....Yes / No
Asthma / Hay Fever.....Yes / No
Diabetes.....Yes / No
Frequent Headaches.....Yes / No
Arthritis / Rheumatism...Yes / No
Neck / Back Pain.....Yes / No
TMD / Jaw Pain.....Yes / No
Osteoporosis.....Yes / No
Periodontal Disease.....Yes / No
Epilepsy / Seizures.....Yes / No
Vertigo.....Yes / No
STD / STI.....Yes / No
AIDS / HIV.....Yes / No
Stomach / Ulcers.....Yes / No
Bowel Disease.....Yes / No

Anemia.....Yes / No
Abnormal Bleeding.....Yes / No
Drug Addiction.....Yes / No
ADD / ADHD.....Yes / No
Neurological Disorder....Yes / No
Autism / Asperger's.....Yes / No
Food Allergies.....Yes / No
Mouth Sores.....Yes / No
IV Drug History.....Yes / No
Chewing Tobacco Use....Yes / No
Smoker.....Yes / No
(Cigarette / Cigar / E-Cigarette or Marijuana

Have you been under a physician's care in the last two years? Yes / No If Yes Explain - _____

Have you had any surgeries / hospitalizations in the past? Type / Year - _____

Have you ever been sick because of dental treatment? Yes / No If Yes Explain - _____

Do you have any other unusual medical problems not listed above? Yes / No If Yes Explain - _____

Women - Pregnant Yes / No Due Date Nursing Yes / No

Medications (Prescription / Herbal / OTC) Name / Reason - _____

Allergies (Drug / Medication) Name / Describe Reaction - _____

Pharmacy Name / Phone -

If more space is needed please use other side or attach another sheet

All of the above information has been reviewed by me and answered to the best of my knowledge. (Signature of parent or guardian if patient is under 18).

FOR OFFICE USE

BLOOD PRESSURE

Signature of Patient: _____ Date: _____

Signature of Doctor: _____ RDH Initials _____ Date: _____