HEALTH QUESTIONNAIRE

Patient Name _____ Address _____

Sex _____ Age _____ Height _____ Weight _____ _____

Name of Employer _____ Home Phone #_____ Cell Phone #_____

Work Phone #_____ Occupation _____ E-mail Address _____

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Directions: Please circle the appropriate answers to the following questions and fill in the blanks where indicated. Please answer all questions completely and accurately. Your answers will remain fully confidential in our records.

1. **Are you in good health?**..... Yes No
2. Have there been any recent changes in your health..... Yes No
   If so what?_____
3. My last physical examination was on _____
4. Are you now under the care of a physician..... Yes No
   If so, what is the condition being treated_____
   _____
5. The name and phone number of my physician is:
   Name:_____
   Phone #_____
6. Have you had a serious illness or operation..... Yes No
   If so, what was the illness or operation: _____
   _____
   _____
   Date:_____
7. **Are you taking any of the following:**
   A. Antibiotics..... Yes No
   B. Anticoagulants (blood thinners)..... Yes No
   C. Aspirin..... Yes No
   D. Antidepressants..... Yes No
   E. Anti-anxiety or Sleep meds..... Yes No
   F. Medicine for high blood pressure..... Yes No
   G. Nitroglycerin..... Yes No
   H. Insulin, Tolbutamide (orinase) or other diabetic drug..... Yes No
   I. Cortisone or other steroids..... Yes No
   J. Oral Contraceptives..... Yes No
   K.. Prolia (Denosumab) or an **Oral** Bisphosphonate Yes No
   L. Zoledronic Acid (Zometa) or other **IV** Bisphosphonates..... Yes No
   M. Recreational drug use..... Yes No
   Which & how often_____
8. Are you taking any other drugs or medication..... Yes No
   If so, what_____
   _____
9. **Are you allergic to or have adversely reacted to:**
   A. Latex ..... Yes No
   B. Penicillin ..... Yes No
   C. Other antibiotics ..... Yes No
   D. Local anesthetic..... Yes No
   E. Dental materials..... Yes No
   F. Metals ..... Yes No
   G. Pain Medication ..... Yes No
   H. Benzodiapines, sedatives, or sleeping pills ..... Yes No
   I. Other Allergies_____
10. **Women**: Are you pregnant or could you be..... Yes No
    If so, how many months? _____
    Are you nursing..... Yes No
11. **Please indicate any history of the following:**
    A. Artificial heart valves or valve problems..... Yes No
    B. Infective Endocarditis..... Yes No
    C. Congenital heart defects..... Yes No
    D. Cardiovascular disease..... Yes No
    E. Congestive Heart Failure (CHF)..... Yes No
    F. High Blood Pressure..... Yes No
    G. Heart attack..... Yes No
    H. Stroke..... Yes No
    I. Persistant or bloody cough..... Yes No
    J. Implants and/or Prosthesis (i.e.. Knee joints, elbow pins, etc.) Yes No
    If so, what type, and when was it placed_____
    K. Any bleeding conditions or disorders..... Yes No
    L. Abnormal bleeding associated with past dental treatment..... Yes No
    M. Asthma..... Yes No
    N. Tobacco use ..... Yes No
    How often_____
    O. Cancer..... Yes No
    P. Radiation treatment for any condition of the face or mouth..... Yes No
    Q. Diabetes..... Yes No
    R. AIDS or HIV+..... Yes No
    S. Sexually Transmitted Diseases..... Yes No
    T. Hepatitis, or any liver condition..... Yes No
    U. Kidney Conditions..... Yes No
    V. Acid Reflux..... Yes No
    W. Bulemia..... Yes No
    X. Lupus or other Autoimmune Disease..... Yes No
    Y. Rheumatoid Arthritis..... Yes No
    Z. Neurological or Mental Health condition..... Yes No
    If so, what_____
12. Do you have any other medical conditions..... Yes No
    If so, please list_____
    _____
13. Have you had any serious trouble associated with previous dental treatment..... Yes No
    If so, explain_____

Doctor's Notes:

By signing below, I certify that the information provided here is correct and true. I agree to notify my dentist immediately if there are any changes to my health, medications or allergies.

Patient/Guardian _____ Date _____

Doctor _____ Date _____