Health Questionnaire

Your general health constitutes an important factor and in combination with other causes, may influence the course of periodontal disease. For your welfare and to assist in establishing a thorough diagnosis for successful treatment, please complete this confidential form.

MEDICAL HISTORY

1. Are you in good health? ..... Yes No
2. Date of last physical examination .....
3. Are you now under the care of a physician? ..... Yes No
   If so, what is the condition being treated? .....
4. Have you ever had excessive bleeding requiring special treatment? ..... Yes No
   If so, what for? .....
5. Have you ever been hospitalized? ..... Yes No
   If so, what was the problem? .....
6. Are you taking any drugs or medicine? ..... Yes No
   If so, what? .....
7. Are you sensitive or allergic to any drugs? ☐ Penicillin: ☐ Tetracycline ☐ Sulfa Drugs ..... Yes No
   If so, what drugs? ..... Have you ever taken Phen-Fen? ..... Yes No
8. **Do you have, or have you had any of the following:** (PLEASE CIRCLE YES OR NO) .....

Y/N Anemia	Y/N High Blood Pressure	Y/N Radiation Treatment of any kind	Y/N Asthma or Hay Fever	Y/N Bone sparing drugs? (i.e FOSAMAX)
Y/N Blood Diseases	Y/N Kidney Disease		Y/N Stroke	
Y/N Rheumatism or Arthritis	Y/N Stomach Ulcers	Y/N Epilepsy	Y/N Excessive Bleeding	Y/N Chemotherapy
Y/N Heart Ailments	Y/N Respiratory Disease	Y/N Nervous Disorders	Y/N Fainting Spells or Seizures	Y/N Current or previous smoker?
Y/N Hepatitis, Jaundice or Liver Disease	Y/N Tumors or Growth	Y/N Allergies	Y/N Glaucoma	
	Y/N Venereal Disease	Y/N Mental Disorders	Y/N Rheumatic Fever	Y/N Bisphosphonate use?
Y/N Head Injuries	Y/N Tuberculosis	Y/N Diabetes	Y/N Sinus Trouble	
Y/N Heart Murmur	Y/N Sleep Apnea	Y/N HIV Positive	Y/N Other _____	Y/N LATEX ALLERGY?

-----Do you wear a cardiac pacemaker? ..... Yes No

9. Have you had heart surgery? ..... Yes No
10. Do you have any disease, condition or problem not listed above that you think I should know about? ..... Yes No
    If so, explain .....
11. (Women) Are you pregnant? If so, how many months? ..... Yes No
12. (Women) Do you have any problems associated with your menstrual period? ..... Yes No

DENTAL HISTORY

13. Do you breathe primarily through your mouth? ..... Yes No
14. Do you have frequent blisters on your lips or mouth? ..... Yes No
15. Do your gums bleed? ..... Yes No
16. Are you aware of a bad taste or odor in your mouth? ..... Yes No
17. Are you troubled with recurring gum boils or abscesses? ..... Yes No
18. Does your jaw ever get "out of joint" or "click"? ..... Yes No
19. Do you clench or grind your teeth? ..... Which? ..... Yes No
20. Have you ever had periodontal treatment? ..... When? ..... Yes No
21. Have you ever had orthodontic treatment? ..... When? ..... Yes No
22. Have you ever had any unfavorable reaction from local anesthetic (Novocaine, etc.)? ..... Yes No
23. Have you ever had any serious trouble associated with any previous dental treatment? ..... Yes No
    If so, explain .....
24. Does dental treatment make you nervous? ..... Yes No

Health History is Correct to the best of My Knowledge

Date. . . /. . . . / . . . . Signature. . . . . .Date. . . /. . . . / . . . . .Signature. . . . . .

Date. . . /. . . . / . . . . .Signature. . . . . Date. . . /. . . . / . . . . .Signature. . . . . .