Health Questionnaire

Please answer each question. Circle Yes or No where applicable.

MEDICAL HISTORY:

1. Are you in good health? Yes No
2. Date of last physical examination _____
3. Are you currently under the care of a physician? Yes No
   If yes, what condition is being treated? _____
4. Have you ever had any serious illness or operation? Yes No
   If yes, what illness or operation? _____
5. Are you taking any drugs or medicine? Yes No
   If yes, what? _____
6. Are you sensitive or allergic to any drugs? ☐ Penicillin ☐ Codeine ☐ Sulfa Drugs ☐ Aspirin Yes No
   If yes, what? _____
7. Do you have, or have you had any of the following:

☐ Anemia	☐ High Blood Pressure	☐ Head Injuries	☐ Allergies
☐ Blood Disease	☐ Jaundice or Liver Disease	☐ Epilepsy	☐ Asthma or Hay Fever
☐ Diabetes	☐ Kidney Disease	☐ Fainting spells or seizures	☐ Respiratory Disease
☐ Excessive Bleeding	☐ Mitralvalve Prolapse	☐ Mental Disorders	☐ Tuberculosis
☐ Heart Ailments	☐ Tumors or Growths	☐ Nervous Disorders	☐ Sinus trouble
☐ Heart Murmur	☐ Radiation treatment	☐ Stroke	☐ Stomach Ulcers
☐ Hepatitis	☐ Rheumatic Fever	☐ Rheumatism or Arthritis	☐ Venereal Disease

8. Do you wear a cardiac pacemaker? Yes No
9. Have you had heart surgery? Yes No
10. Have you had any type of joint replacement surgery? Yes No
    If yes, what type? _____
11. Do you have any condition or problem not listed above that you feel the doctor should know about? Yes No
    If yes, explain _____
12. Women: Are you pregnant? Yes No

DENTAL HISTORY:

13. Have you ever had any unfavorable reaction from a local anesthetic? Yes No
14. Have you had any serious trouble associated with previous dental treatment? Yes No
    If yes, explain _____
15. How long since your last Dental Treatment? _____
16. How long since your last full set of dental X-rays? _____
17. Is there anything you would like to change about your teeth? Yes No
    If yes, what? ☐ Color ☐ Sensitivity ☐ Other _____
18. Does dental treatment make you nervous? Yes No
    If yes check: ☐ Slightly ☐ Moderately ☐ Extremely

Date		
BP		
Pulse		
Temp		

DO NOT WRITE IN THIS SPACE

CONSENT FOR TREATMENT:

I here by grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form to administer any treatment; or to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

Signature _____ Date _____ Relationship _____

Authorization must be signed by the patient; but, if the patient is a minor or is physically or mentally incompetent the consent must be signed by legal guardian or nearest relative.