

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:

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