

HEALTH QUESTIONNAIRE

These questions are for your benefit and assure that treatment will take place into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care.

1. Are you in good health? _____ Date of physical exam _____
2. Are you now under the care of a physician? _____
3. If so, what is the condition being treated? _____
4. Have you ever had any serious illness or operation? If so, what was the illness or operation? _____
5. Have you ever been hospitalized? If so, what was the problem? _____
6. Are you taking any Medication, Drugs or Herbs? _____
7. Are you taking any recreational drugs (marijuana or cocaine, etc)? If so, what? _____
8. Have you ever been pre-medicated with antibiotics for your dental treatment? _____
9. Are you sensitive or allergic to any drugs or materials? ☐ Penicillin ☐ Sulfa Drugs ☐ Aspirin ☐ Codeine ☐ Latex ☐ Other
If other, what drugs? _____

Do you have or have you had any of the following: Circle "Y" for Yes or "N" for No- answer all conditions)

Y N Herpes	Y N Headaches	Y N Heart Failure	Y N Kidney Disease
Y N Joint Replacement	Y N X-ray or Cobalt Treatment	Y N Stroke	Y N Glaucoma
Y N Scarlet Fever	Y N Radiation treatment	Y N Arthritis	Y N Ulcers
Y N Chemotherapy	Y N Cancer	Y N Cold Sores	Y N Tonsillitis
Y N Nervous Disorder	Y N Rheumatism	Y N Liver Disease	Y N Sinus Trouble
Y N Hay Fever	Y N Heart Ailments	Y N Mental Disorder	Y N Stomach Ulcers
Y N Bruise Easily	Y N Fainting Spells	Y N Pain in Jaw Joints	Y N Tumors & Growth
Y N Cerebral Palsy	Y N Sickle Disease	Y N TMJ	Y N Venereal Disease syphilis
Y N Allergies to Metal	Y N Snoring	Y N Asthma	Y N Diabetes
Y N Mitral Valve Prolapse	Y N Seizures	Y N Emphysema	Y N Hemophilia
Y N High Blood Pressure	Y N Chicken Pox	Y N Blood Disease	Y N Heart Murmur
Y N HIV Related Complex	Y N Heart Attack	Y N Thyroid Disease	Y N Angina Pectoris
Y N Respiratory Disease	Y N Cortisone Medicine	Y N Artificial Prosthesis	Y N Allergies or Hives
Y N Epilepsy or Seizures	Y N Rheumatic Fever	Y N Sleep apnea	Y N AIDS
Y N Psychiatric Treatment	Y N Excessive Bleeding	Y N Difficulty Swallowing	Y N Congenital Heart Lesions
Y N Hepatitis or Jaundice	Y N Tuberculosis (T.B.)	Y N Blood Transfusion	Y N Osteoporosis
Y N Head Injuries	Y N Drug Addictions	Y N Implants	Y N Anemia

10. Do you have any disease, condition or problem not listed that you think we should know about? _____
11. Do you wear a cardiac pacemaker, or have you had heart surgery? _____ When? _____
12. Do you smoke? ____ If yes, how much? _____ Cigarettes or Cigars (please circle)
13. Have you ever taken the drugs Fen-Phen, Redux or any Diet Drug? If yes, which one? _____
14. (Women) Are you pregnant? If so How many months? _____
15. (Women) Do you have any problems associated with your menstrual period? _____
16. (Women) Do you take any birth control medication or hormones? _____
17. Have you ever had a local anesthetic (Novocaine, etc.)? _____ Any side effects? _____
18. Have you had any serious trouble associated with any previous dental treatment? _____
19. How long since your last full mouth X-rays? _____ Weeks _____ Months _____ Years
20. How long since you last dental treatment? _____ Weeks _____ Months _____ Years
21. Does dental treatment make you nervous? _____

☐ I hereby acknowledge I have received a copy of this practice's **NOTICE OF PRIVACY PRACTICES**. I further understand that the practice will offer me updated to this **NOTICE OF PRIVACY PRACTICES** should it be amended, modified, or changes in any way.

☐ I have received a copy of the **DENTAL MATERIAL FACT SHEET** as required by law.

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medications change, I will, without fail inform the doctor at my next appointment.

Signed _____ Date _____

Consent for Treatment

I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; to perform such operations as may be deemed necessary or advisable in the diagnose and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

All services are rendered and accepted under the terms and conditions printed on the reverse hereof:

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patients is physically or mentally incompetent.

Signed _____ Date _____