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Family & Cosmetic Dentistry

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HEALTH QUESTIONNAIRE

In order to render an optimum health service it is necessary to obtain a variety of vital personal information.

ALL INFORMATION IS OF COURSE CONFIDENTIAL

Name _____ Birthdate _____
Address _____ Postal Code _____ Telephone _____
Employer _____ Telephone _____ Today's Date _____
Physician _____ Address _____ Telephone _____
Dental Insurance Company _____
Email _____

PLEASE ANSWER ALL THE FOLLOWING INFORMATION BY CIRCLING YES OR NO

Are you in good health Yes No
Has there been any change in your general health this past year Yes No
When was your last physical examination _____
Are you under the care of a physician Yes No
If so, what is the condition being treated _____
Have you been hospitalized for any serious illness or operation Yes No
If so, what was the illness or operation _____
Do you have any of the following diseases or problems
Rheumatic fever or rheumatic heart disease Yes No
Congenital heart disease or heart murmur Yes No
Cardiovascular disease (heart, heart attack, coronary insufficiency, coronary occlusion, high blood pressure
arteriosclerosis, stroke, mitral valve prolapse, heart murmur) Yes No
Do you have pain in the chest upon exertion Yes No
Are you ever short of breath after mild exercise Yes No
Do your ankles swell Yes No
Do you get short of breath when you lie down, or do you require extra pillows when you sleep Yes No
Allergy (to what?) _____
Sinus trouble Yes No
Asthma or hay fever Yes No
Hives or skin rash Yes No
Psychiatric treatment Yes No
Fainting spells or seizures Yes No
Diabetes Yes No
Do you have to urinate (pass water) more than six times a day Yes No
Are you thirsty much of the time Yes No
Does your mouth frequently get dry Yes No
Hepatitis, jaundice or liver disease Yes No
Arthritis Yes No
Inflammatory rheumatism (painful swollen joints) Yes No
Stomach ulcers Yes No
Thyroid trouble Yes No
Kidney trouble Yes No
Do you have a persistent cough or cough up blood Yes No
Low blood pressure Yes No
Sexually transmitted disease Yes No
AIDS or AIDS related complex Yes No
Other (i.e. contact lens wearer, etc.) _____

Have you had abnormal bleeding associated with previous extractions, surgery or trauma	Yes	No
Do you bruise easily	Yes	No
Have you ever required a blood transfusion	Yes	No
Explain the circumstances _____		
Are you taking any of the following		
Antibiotics or sulfa drugs	Yes	No
Anticoagulants (blood thinners)	Yes	No
Medicine for high blood pressure	Yes	No
Cortisone (steroids)	Yes	No
Tranquilizers	Yes	No
Aspirin	Yes	No
Insulin, tolbutamide (Osrinase) or similar drug	Yes	No
Digitalis or drugs for heart trouble	Yes	No
Nitroglycerin	Yes	No
List other _____		
Have you an allergic or other reactions to:		
Local anaesthetics (freezing), penicillin or other antibiotics	Yes	No
Any other drugs	Yes	No
Women-Are you pregnant	Yes	No
Do you have young children	Yes	No
Is there any other condition or problem we should know about	Yes	No
Do you smoke? (if so, how many and for how long _____)	Yes	No

DENTAL HISTORY

When was your last dental visit _____		
What services were provided _____		
Have you been seeing a dentist regularly	Yes	No
Are you interested in keeping your teeth	Yes	No
Are you satisfied with the appearance of your teeth	Yes	No
Have you had work done with local anaesthetic (freezing) before	Yes	No
When was your last complete exam and series of x-rays taken _____		
How often do you brush you teeth _____		
How often do you floss _____		
Do your teeth ache	Yes	No
Do your gums bleed when brushing	Yes	No
Are you aware of or concerned about a breath problem	Yes	No
Are you aware of any tenderness or swelling in your mouth	Yes	No
Do you have any loose teeth	Yes	No
Does food get caught between any of your teeth	Yes	No
Do you have pain when chewing	Yes	No
Do you notice any clicking or cracking or locking of your jaws	Yes	No
Do you have any sores in your mouth	Yes	No
Have you been in any car accidents or experienced any blows to the jaw	Yes	No
Have you had a bad whiplash type injury	Yes	No
Have you been treated for periodontal (gum) disease	Yes	No
Do you suffer from frequent headaches or neck pain	Yes	No
Are you nervous or tense about the dentist	Yes	No
Have you had any serious or special problems with past treatment	Yes	No
Would you be happy with dentures	Yes	No

I authorize any dental and oral surgical procedures including the use of radiographs (x-rays) and drugs that are felt to be necessary for my oral health and I assume the responsibility for fees associated with those procedures. Expect that any procedure beyond the routine will be explained beforehand.

Dentist's Signature

Signature of Patient or Guardian

Please Note: There is no charge for missed appointments in our office, providing 24 hours notice is given.