HEALTH QUESTIONNAIRE

MEDICAL HISTORY

Name of Physician_____ Phone: _____

Your current physical health is: GOOD FAIR POOR

Are you currently under the care of a physician? Y N Please explain: _____

Are you taking any prescription/over the counter drug(s)? Y N Please explain: _____

Please list each one: _____

Have you ever had any serious illness or operation? Y N Please explain:_____

DO YOU HAVE TO BE PREMEDICATED BEFORE DENTAL TREATMENT? Y N **HAVE YOU EVER TAKEN PHEN-FEN? Y N**

IF SO, HAVE YOU CONSULTED YOUR M.D. REGARDING HEART CONDITION. Please explain: _____

FOR WOMEN

Are you taking birth control pills? Y N Are you pregnant? Y N Are you nursing? Y N

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Y	N	Heart Attack/Stroke	Y	N	High or Low Blood Pressure	Y	N	Ulcers
Y	N	Cancer/Chemotherapy	Y	N	Fever Blister	Y	N	Congenital Heart Defect
Y	N	Heart Murmur	Y	N	Severe/Frequent Headaches	Y	N	Radiation Treatment
Y	N	Rheumatic Fever	Y	N	Cardiac Pacemaker	Y	N	Asthma
Y	N	Heart Surgery/Pacemaker	Y	N	Psychiatric Problems	Y	N	Difficulty Breathing
Y	N	Shingles	Y	N	Epilepsy/Seizures/Fainting	Y	N	Hospitalized for any reason
Y	N	Mitral Valve Prolapse	Y	N	Diabetes	Y	N	Hepatitis
Y	N	Kidney Problems	Y	N	Drug/Alcohol Abuse	Y	N	Blood Transfusion
Y	N	Artificial Bones/Joints	Y	N	Venereal Disease	Y	N	Emphysema
Y	N	Artificial Valves	Y	N	Hemophilia/Abnormal Bleeding	Y	N	HIV+/AIDS
Y	N	Sinus Problems	Y	N	Glaucoma	Y	N	Anemia
Y	N	Tuberculosis (TB)	Y	N	Colitis	Y	N	Arthritis

Please list any medical condition(s) that you have ever had: _____

Are you allergic to any of the following drugs or materials?

Y	N	Penicillin	Y	N	Tetracycline	Y	N	Aspirin
Y	N	Erythromycin	Y	N	Codeine	Y	N	Antibiotics
Y	N	Sulfa Drugs	Y	N	Latex	Y	N	Other

Please list any other drugs that you are allergic to:_____

MEDICAL HISTORY

Previous Dentist_____ Phone: _____

Dental Complaint at this moment? _____

Have you ever had any unfavorable reaction from a local anesthetic? _____

Have you ever had any serious trouble associated with any previous dental treatment? _____

Explain: _____

How long since last dental X-Rays of your entire mouth? _____ How long since last dental treatment? _____

Do you have or do you use any of the following?

Y	N	Bleeding gums	Y	N	Complications from extractions	Y	N	Water jet device
Y	N	Food impaction	Y	N	Periodontal (gums) treatment	Y	N	Fluoride supplements
Y	N	Clenching or grinding	Y	N	Orthodontic treatment	Y	N	Fluoride treatments
Y	N	Bad breath	Y	N	Cigarettes, pipe or cigar smoking			
Y	N	Unpleasant taste	Y	N	Dental floss			

CONSENT FOR TREATMENT: I hereby authorized to the dentist(s) in charge of the care of the patient whose name appears on this form to administer any treatment, or to administer such anesthetic, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such dental operations or procedures as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

Signed _____ Date_____

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