

Name _____ Date of Birth _____
first middle last
 Doctor _____ Insurance _____ Account # _____

HEALTH QUESTIONNAIRE

Please answer each question. Circle **Yes** or **No** where applicable. Example: Are you alive? **(Yes)** No

MEDICAL HISTORY

1. Are you in good health? **Yes** No
2. Date of last physical examination _____
3. Are you now under the care of a physician? **Yes** No
 If so, what is the condition being treated? _____
4. Have you ever had any serious illness or operation? **Yes** No
 If so, what illness or operation? _____
5. Have you ever been hospitalized? **Yes** No
 If so, what was the problem? _____
6. Are you taking any drugs or medicine? **Yes** No
 If so, what? _____ What dosage? _____
7. Are you sensitive or allergic to any drugs? Penicillin; Tetracycline; Sulfa Drugs; Other **Yes** No
 If other, what drugs? _____
8. Do you have, or have you had any of the following: (Please check known conditions) **Yes** No

<input type="checkbox"/> Anemia	<input type="checkbox"/> Blood Diseases	<input type="checkbox"/> Rheumatism or Arthritis	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Heart Ailments	<input type="checkbox"/> Hepatitis, Jaundice or Liver Disease	<input type="checkbox"/> Head Injuries	<input type="checkbox"/> Mental Disorders
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Stomach Ulcers	<input type="checkbox"/> Stroke
<input type="checkbox"/> Respiratory Disease	<input type="checkbox"/> Tumors or Growths	<input type="checkbox"/> Difficulty in Swallowing	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Radiation Treatment of any kind	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Herpes
<input type="checkbox"/> Nervous Disorders	<input type="checkbox"/> Allergies	<input type="checkbox"/> Acquired Immune Deficiency Syndrome	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Asthma or Hay Fever	<input type="checkbox"/> Other _____	
<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Fainting Spells or Seizures		
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Artificial Prosthesis (Implants)		
9. Do you wear a cardiac pacemaker? **Yes** No
10. Have you had heart surgery? **Yes** No
11. Do you have any disease, condition or problem not listed that you think I should know about? **Yes** No
 If so, what? _____
12. Have you had a joint replacement? **Yes** No
13. (Women) Are you pregnant? If so, how many months? **Yes** No
14. (Women) Do you have any problems associated with your menstrual period? **Yes** No

DENTAL HISTORY

1. Have you ever had a local anesthetic (Novacaine, etc.)? **Yes** No
2. Have you ever had any unfavorable reaction from a local anesthetic? **Yes** No
3. Have you had any serious trouble associated with any previous dental treatment? **Yes** No
 If so, explain _____
4. How long since your last full Mouth X-rays? _____
5. How long since your last Dental treatment? _____
6. Does dental treatment make you nervous? **Yes** No
 If Yes, Check : Slightly Moderate Extremely
7. Would you desire to be pre-sedated? **Yes** No

Date _____ Signature _____

Year 2
 Changes in Health _____

Date _____ Signature _____

Year 3
 Changes in Health _____

Date _____ Signature _____

Health Questionnaire MUST be updated every year!

	Year 1	Year 2	Year 3
Date	_____	_____	_____
BP	____/____	____/____	____/____
Pulse	_____	_____	_____
Temp	_____	_____	_____
By	_____	_____	_____
DO NOT WRITE IN THIS SPACE			

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 any treatment; or to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such operations 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.

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

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.

Relationship to the patient: _____