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

☐ Anemia	☐ Blood Diseases	☐ Rheumatism or Arthritis	☐ Epilepsy
☐ Heart Ailments	☐ Hepatitis, Jaundice or Liver Disease	☐ Head Injuries	☐ Mental Disorders
☐ High Blood Pressure	☐ Kidney Disease	☐ Stomach Ulcers	☐ Stroke
☐ Respiratory Disease	☐ Tumors or Growths	☐ Difficulty in Swallowing	☐ Glaucoma
☐ Tuberculosis	☐ Radiation Treatment of any kind	☐ Venereal Disease	☐ Herpes
☐ Nervous Disorders	☐ Allergies	☐ Acquired Immune Deficiency Syndrome	☐ Sinus Trouble
☐ Diabetes	☐ Asthma or Hay Fever		
☐ Excessive Bleeding	☐ Fainting Spells or Seizures	☐ Other _____	
☐ Rheumatic Fever	☐ 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: _____