HEALTH QUESTIONNAIRE - Adult

Confidential

Correct dental and medical history information is essential for this office to provide individual and appropriate care to meet your dental needs safely and efficiently. Incorrect or incomplete information can be dangerous to your health.

Patients Name_____Date of Birth_____Today's Date_____

DENTAL HISTORY

1. Why are you now seeking dental treatment?_____
2. When was your last dental visit?_____Treatment?_____
3. If you are new to our practice, why are you changing dentists?_____
4. Any problems with previous dental treatment?_____
5. Does dental treatment make you nervous? ☐ No ☐ Slightly ☐ Moderately ☐ Extremely
6. Check (√) if you have, or ever had, any of the following:

- ❑ Bad breath or unpleasant taste
- ❑ Bleeding or sore gums
- ❑ Loose or shifting teeth
- ❑ Food traps between your teeth

Sensitive teeth:

- ❑ Cold / Hot
- ❑ Sweets
- ❑ Chewing
- ❑ All the time?

- ❑ Burning tongue/mouth
- ❑ Swelling or sores in mouth
- ❑ Mouth breathing or dry mouth

Oral Habits:

- ❑ Smoking _____
- ❑ Chewing tobacco
- ❑ Nails or cheek/lip biting
- ❑ Clenching or grinding teeth
- ❑ Others _____

- ❑ Periodontal therapy
- ❑ Dental Implants
- ❑ Orthodontic treatment
- ❑ Changes in your bite
- ❑ Oral, head or neck surgery
- ❑ Complications with extractions
- ❑ Snoring
- ❑ Have been told that you stop breathing while sleeping

7. Have you ever experienced the following problems with your jaw?

- ❑ Clicking or popping in the joint
- ❑ Pain in the joint, ear or face
- ❑ Difficulty opening or closing your mouth
- ❑ Difficulty chewing or swallowing
- ❑ Head, neck or jaw injuries
- ❑ Frequent headaches
- ❑ History of T.M.D. (tempero-mandibular disorders)
- ❑ Other _____

8. How often do you Brush?_____ Floss?_____ Other?_____
9. How often do you have professional dental cleanings?_____
10. Are you happy with the color and condition of your teeth? ☐ Yes ☐ No

Comments_____

_____

MEDICAL HISTORY

1. Name of Physician _____Date of last visit _____

   Physicians address _____
   Street City

   Phone # _____
2. Do you see your physician regularly for a particular condition? ☐ No ☐ Yes

   Explain_____
3. Have you ever had a serious illness or operation? ☐ No ☐ Yes

   Explain_____
4. Have you ever had excessive bleeding from an extraction/wound? Or do cuts take a long time to heal? ☐ No ☐ Yes
5. Do you use tobacco in any form? ☐ No ☐ Yes How much?_____
6. Do you drink alcoholic beverages daily? ☐ No ☐ Yes How much?_____
7. (WOMEN) Are you pregnant? ☐ No ☐ Yes When are you due?_____

   Do you anticipate becoming pregnant? ☐ No ☐ Yes Do you use birth control pills? ☐ No ☐ Yes

8. Place a check (√) to indicate if you have had any of the following:

- ❑ Heart problems ? _____
- ❑ Heart surgery
- ❑ Pacemaker
- ❑ Artificial heart valves
- ❑ Heart murmur
- ❑ Mitral valve prolapsed
- ❑ Rheumatic fever
- ❑ Angina
- ❑ Shortness of breath / freq. tired
- ❑ Swelling of feet or ankles
- ❑ Respiratory disease ? _____
- ❑ Blood disease
- ❑ Anemia
- ❑ Bruise easily
- ❑ Circulatory problems
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Osteoporosis
- ❑ Tuberculosis
  - ❑ Persistent bloody cough
  - ❑ Unexplained weight loss
  - ❑ Night sweats
  - ❑ High fevers
- ❑ Asthma
- ❑ Airborne allergies
- ❑ Emphysema
- ❑ Arthritis / Rheumatism
- ❑ Back problems
- ❑ Artificial joints / limbs
- ❑ Skin rashes or eruptions
- ❑ Cancer, Tumors or Growths ? _____
- ❑ Radiation / Chemotherapy
- ❑ Diabetes
- ❑ Thyroid problems
- ❑ Swollen glands in the neck
- ❑ Hoarseness or sore throat
- ❑ Sinus problems
- ❑ Hearing problems
- ❑ Eye disorders
- ❑ Contact lenses
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Hepatitis, type_____
- ❑ Jaundice
- ❑ Ulcers / Colitis
- ❑ Special Diet
- ❑ Stroke
- ❑ Epilepsy / Seizures
- ❑ Fainting / Dizziness
- ❑ Nerve or nervous problems
- ❑ Psychiatric Care
- ❑ Chemical dependency
- ❑ Immuno-suppressive disorder
- ❑ A.I.D.S.
- ❑ HIV positive
- ❑ Herpes
- ❑ Venereal disease
- ❑ Others?_____

Comments_____

_____

MEDICATIONS ☐ **None**

- ❑ Antibiotics
- ❑ Pain medication
- ❑ Heart / BP meds.
- ❑ Nitroglycerine
- ❑ Allergy / cold remedies
- ❑ Recreational Drugs
- ❑ Sedatives/Tranquilizers
- ❑ Aspirin, Blood thinners
- ❑ Bisphosphonates
- ❑ Steroids
- ❑ Oral Contraceptives
- ❑ Others

List **all** medications and dosages

_____
_____
_____
_____
_____
_____

Have you ever had to premedicate with antibiotics or alter your medications prior to dental treatment or any surgery?

☐ No ☐ Yes

ALLERGIES ☐ **None**

- ❑ Penicillin's
- ❑ Sulfa drugs
- ❑ Other Antibiotics
- ❑ Aspirin or NSAID's
- ❑ Codeine
- ❑ Local Anesthetics

Latex Rubber Allergy? ☐ **No** ☐ **Yes**

Other Allergies? _____

_____

_____

Have you ever received IV bisphosphonates (ex/ Zometa or Aredia) or taken oral bisphosphonates (ex/ Fosamax, Actenol or Boniva)?

☐ No ☐ Yes if so, when?_____

Pharmacy Name_____ Phone #_____

Is there any disease, condition or problem not listed above that you think we should know about? ☐ No ☐ Yes

Explain_____

To the best of my knowledge, all of the preceding answers are true and correct. ANY CHANGES IN MY HEALTH STATUS WILL BE REPORTED TO THIS OFFICE AT THE EARLIEST POSSIBLE TIME.

Permission to release health information: I grant the right to the dentist to release health information obtained from me, and information about my dental treatment to third party payers and/or other health practitioners only if relating to my dental needs.

Person completing this form_____Date _____
Signature

If other than the patient, indicate relationship _____

Reviewed health questionnaire with the patient_____Date _____
Signature – Doctor / Hygienist