Health Questionnaire

*Name: _____ *Date: _____

In order to evaluate your dental health and plan the best possible treatment options for you, it is important for us to record a complete medical history.

The following is for our records only and is considered confidential.

*Are you currently under the care of a doctor? Yes ◯ No ◯

Doctor's Name: _____ Phone Number: _____

Check any of the following which you have had or have at present.

- ☐ Rheumatic Fever
- ☐ Heart Murmur
- ☐ Mitral Valve Prolapse
- ☐ Heart Failure
- ☐ Heart Attack
- ☐ Angina Pectoris
- ☐ Heart Rythm Disorder
- ☐ High Blood Pressure
- ☐ Congenital Heart Defects
- ☐ Artificial Heart Valve
- ☐ Pacemaker
- ☐ Heart Surgery
- ☐ Artificial Joint
- ☐ Organ Transplant
- ☐ Stroke
- ☐ Aneurysm
- ☐ Kidney Trouble
- ☐ Dialysis
- ☐ Ulcers or Stomach Disorder
- ☐ Mentally Handicapped
- ☐ Brain Injury
- ☐ Scarlet Fever
- ☐ Diabetes
- ☐ Hepatitis: Type _____
- ☐ Jaundice
- ☐ Liver Disease
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Emphysema
- ☐ Thyroid Disease
- ☐ Cancer, Leukemia
- ☐ Radiation Treatment
- ☐ Chemotherapy
- ☐ Cortisone / Steroid Treatment
- ☐ HIV / AIDS
- ☐ Blood Transfusion
- ☐ Blood Disorder
- ☐ Anemia
- ☐ Hemophilia
- ☐ Sickle Cell Trait / Disease
- ☐ Glaucoma
- ☐ Seizure Disorder (Epilepsy)
- ☐ Psychiatric / Mental Illness
- ☐ Venereal Disease
- ☐ Alcohol Abuse
- ☐ Eating Disorder

Medications

Please list all your present medications and any medicine, which you may have taken within the last 12 months. Include prescriptions and over the counter medication (eg. aspirin, vitamins, herbal/alternative medications.)

Drug Name(s)	Dosage(s)	Times Taken

Allergies: Please list drugs, food, and others and your reaction (eg: rash, fever, hives, swelling)

Allergic To	Reaction

***Have you ever had an unpleasant reaction to any of the following?**

Aspirin	Yes ◯	No ◯
Penicillin	Yes ◯	No ◯
Barbituates and Sedatives	Yes ◯	No ◯
Valium	Yes ◯	No ◯
Codeine or Demerol	Yes ◯	No ◯
Latex / Rubber Products	Yes ◯	No ◯

***Present State of Health / Functional Inquiry**

Has your energy level decreased lately?	Yes ◯	No ◯
Has your weight changed by more than 5 pounds in the last year?	Yes ◯	No ◯
Have you had a change in your appetite?	Yes ◯	No ◯
Do you follow any special diet?	Yes ◯	No ◯
Do you bleed for more than 5 minutes if you cut yourself?	Yes ◯	No ◯
Do you get frequent nosebleeds?	Yes ◯	No ◯

Do you have any stiffness or restriction of the movement of your neck?	Yes ◯	No ◯
Do you have frequent, severe headaches?	Yes ◯	No ◯
Have you ever fainted?	Yes ◯	No ◯
Do you ever get a pounding or fluttering feeling in your chest?	Yes ◯	No ◯
Do you have any chest pain on exertion?	Yes ◯	No ◯
Do your ankles swell?	Yes ◯	No ◯
Do you get short of breath after mild exertion (2 flights of stairs)?	Yes ◯	No ◯
Do you have any sinus trouble?	Yes ◯	No ◯
Do you have trouble breathing through your nose?	Yes ◯	No ◯
Do you have a persistent cough?	Yes ◯	No ◯
Have you ever coughed up blood?	Yes ◯	No ◯
Have you ever vomited blood?	Yes ◯	No ◯
Do you urinate more than 6 times a day?	Yes ◯	No ◯
Are you thirsty much of the time?	Yes ◯	No ◯
Do you find yourself hot or cold when others around you are not?	Yes ◯	No ◯

***Past Medical History**

Have you been examined by your physician within the last year?	Yes ◯	No ◯
Has there been any change in your general health within the last year?	Yes ◯	No ◯
Have you ever had a serious illness resulting in a protracted absence from business or school?	Yes ◯	No ◯
Have you ever had to stay overnight in a hospital?	Yes ◯	No ◯
Have you ever had any operations?	Yes ◯	No ◯
Have you ever had surgery or radiation treatment for a tumor or growth?	Yes ◯	No ◯

Previous Hospitalizations and Surgeries

Reason	When	Where

Have you ever smoked? Yes ◯ No ◯

Do you currently smoke? Yes ◯ No ◯

If yes, since when? _____ How much per day? _____

Do any diseases run in your family? Yes ◯ No ◯

Which ones? _____

Do you wear contact lenses? Yes ◯ No ◯

Women Only

Are you pregnant now? Yes ◯ No ◯

Do you take birth control pills? Yes ◯ No ◯

Are you breast-feeding? Yes ◯ No ◯

***Dental History**

Do you think that your teeth are affecting your health in any way? Yes ◯ No ◯

Are you dissatisfied with the appearance of your teeth or smile? Yes ◯ No ◯

Do your gums bleed? Yes ◯ No ◯

Do you have frequent sores in your mouth or cold sores? Yes ◯ No ◯

Do you have difficulty chewing or problems in your bite? Yes ◯ No ◯

Is it difficult for you to open your mouth as wide as you would like? Yes ◯ No ◯

Does your jaw click when you chew or open wide? Yes ◯ No ◯

Have you ever experienced an unpleasant reaction to a dental anesthetic (freezing)? Yes ◯ No ◯

Are you worried or anxious about receiving dental treatment? Yes ◯ No ◯

Have you ever had any injury to your face or jaws? Yes ◯ No ◯

Have you ever required or been told that you require antibiotics prior to dental work Yes ◯ No ◯

Do you brush daily? Yes ◯ No ◯

Do you floss daily? Yes ◯ No ◯

When was your last dental visit? _____

What was done? _____

When were your last dental x-rays taken? _____

Who was your last dentist? _____

Please place a mark on the line below, the degree of anxiousness you experience when having dental work done:

Not Anxious at All ---------- Greatest Amount of Anxiety Imaginable

Patient Certification and Consent for Treatment

This section will be printed out and signed upon your arrival at Time to Care Dental Group.

I, the undersigned certify that all of the above medical and dental information is true to my knowledge. I consent to the performing of such dental procedures as agreed upon with the dentist to be necessary or advisable, including the use of local anesthetic as indicated If I ever have a change in my health, or if my medicine changes, I will inform the dental staff at the next appointment without fail.

Patient's Signature:

(Parent or Guardian Signature if Under Age of Majority)

Date:

Updates

Changes (if any)	Date & Initial

**Indicates Required Field*

Submit