HEALTH QUESTIONNAIRE

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care.

Please answer each question.

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
4. Have you ever had a 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 medication? ..... YES NO
   If so, what? _____
7. Are you allergic to any drugs? ..... YES NO
   Please circle: Aspirin Codeine Penicillin Tetracyclin Sulfa Drugs Other _____
8. Are you allergic to Latex? ..... YES NO
9. Do you or have you taken any medication to treat Osteoporosis? ..... YES NO
10. Have you had or do you have any of the following? (Please Circle)

Anemia	YES	NO	Chicken Pox	YES	NO	Pain in the Jaw Joints	YES	NO
Herpes	YES	NO	Sinus Trouble	YES	NO	Respiratory Disease	YES	NO
Stroke	YES	NO	Blood Disease	YES	NO	Sickle Cell Disease	YES	NO
Ulcers	YES	NO	Drug Addiction	YES	NO	Tuberculosis (T.B.)	YES	NO
Diabetes	YES	NO	Kidney Disease	YES	NO	Epilepsy or Seizures	YES	NO
Glaucoma	YES	NO	Stomach Ulcers	YES	NO	Artificial Prosthesis	YES	NO
Arthritis	YES	NO	Angina Pectoris	YES	NO	Psychiatric Treatment	YES	NO
Emphysema	YES	NO	Mental Disorder	YES	NO	Congenital Heart Lesions	YES	NO
Hay Fever	YES	NO	Rheumatic Fever	YES	NO	Difficulty in Swallowing	YES	NO
Tonsilitis	YES	NO	Thyroid Disease	YES	NO	Heart Aliments or Attack	YES	NO
Cold Sores	YES	NO	Cerebral Palsy	YES	NO	X-Ray or Cobalt Treatment	YES	NO
Hemophilia	YES	NO	Blood Transfusion	YES	NO	Fainting Spells or Seizures	YES	NO
Rheumatism	YES	NO	Joint Replacement	YES	NO	Chemotherapy (Cancer,Leukemia)	YES	NO
Heart Murmur	YES	NO	Nervous Disorders	YES	NO	Radiation Treatment of any kind	YES	NO
Weight loss medication such as			Tumors or Growths	YES	NO	Hepatitis or Jaundice	YES	NO
Fen-Phen, Pondimen or Redux	YES	NO	Allergies or Hives	YES	NO	Venereal Disease (Syphillis, gonorrhea)	YES	NO
Bruise Easily	YES	NO	Cortisone Medication	YES	NO	Acquired Immune Deficiency Syndrome (AIDS)	YES	NO
Head Injuries	YES	NO	Excessive Bleeding	YES	NO	TMJ (Temporomandibular Joint)	YES	NO
Heart Failure	YES	NO	Asthma	YES	NO	Other _____		
Liver Disease	YES	NO	High Blood Pressure	YES	NO			
Scarlet Fever	YES	NO	AIDS Related Complex	YES	NO			

11. Do you wear a cardiac pacemaker? ..... YES NO
12. Have you had heart surgery? ..... YES NO
13. Do you have any disease, condition or problem not listed that you think I should know about? ..... YES NO

_____

FOR WOMEN ONLY

1. Are you pregnant? ..... YES NO
2. Do you take birth control pills? ..... YES NO

Dental Information

1. Have you ever had a local anesthetic (Lidocaine, Carbocaine, 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. Does dental treatment make you nervous? ..... YES NO

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medications change, I will, without fail, inform the doctor at my next appointment.

Date_____ Signature _____ Year 3
Date_____ Signature _____
Year 2
*Date*_____ *Signature* _____ Year 4
*Date*_____ *Signature* _____

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 such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such operations as my be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anethestics 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: _____