Health Questionnaire

Date _____

Name_____ Address_____
(number & street)

_____ ( )_____-_____; ( )_____-_____
(city) (state) (zip code) (home and business phone with area code)

Age_____ Sex_____ Married_____ Spouse's Name_____ Single_____

Occupation_____ Social Security Number_____ Date of Birth_____

Name of General Dentist_____ Who referred you to this office_____

Closest Relative_____ Phone Number ( )_____-_____

Dental Insurance_____ Nick Name_____

PLEASE ANSWER EACH QUESTION: the back may be used for explanations Circle one

1. Have you had any specific periodontal (gum) treatment?……...……...……...Yes No
2. Are your teeth sensitive to hot, cold, or when cleaned?……..……Yes No
3. Do you have bleeding gums?…….……..Yes No
4. Are you dissatisfied with the appearance or function of your teeth?…….……..Yes No
5. Do you experience difficulty opening your mouth wide?…….…...Yes No
6. Does your jaw click or pop when you chew?……..……Yes No
7. Your physician's name_____ number ( )_____-_____
8. Have you been hospitalized in the last two years?……...Yes No
9. Have you been under the care of a physician in the past two years?……...Yes No
10. What medications have you taken in the last two years?

11. Are you allergic to aspirin, penicillin or any other medications?…….…..…Yes No
12. Have you experienced excessive bleeding requiring special treatment?…….....Yes No
13. Do you have AIDS or have you ever tested HIV positive?…….…...Yes No
14. Have you been a patient in this practice before, if so when?……..……Yes No
15. Have you seen a periodontist before? If so, who and when?…….…....Yes No
16. Have you ever had any serious illness or disease?……..…Yes No
17. Are you apprehensive about dental treatment?…….…..…Yes No
18. Have you ever smoked or used tobacco products on a regular basis?……..…...Yes No
19. Do you presently smoke or use tobacco products?…….....Yes No
20. (Women) Are you pregnant or nursing?…….....Yes No
21. Circle any of the following that apply:

Heart trouble	High blood pressure	Diabetes
Congenital heart disease	Psychiatric treatment	Epilepsy
Heart murmur (valvular disease)	Tuberculosis	Cancer
Rheumatic fever	Hepatitis	Glaucoma
Kidney disease	Thyroid disease	Stroke
Artificial hip or joint replacement	Head or Neck irradiation	Asthma
Sinus problems	Daily Aspirin (MD or self prescribed)	

22. What concerns do you have regarding your oral health:

Patient's Signature_____ Reviewed By_____