Health History Questionnaire – Confidential

Name_____ Date of Birth_____

1. Have you had any health problems in the past 5 years? Yes No Explain_____
2. Have you seen a physician/other health care provider in the past 2 years? Yes No
   Physician's name: _____ Phone#_____
3. Are there activities your doctor says you cannot do? Yes No
4. Have you been hospitalized or had a serious illness in the past 5 years? Yes No
5. Have you ever had a bleeding problem? Yes No

Baseline Vital Signs	Temp	Pulse	Resp	BP:				

Please circle the appropriate response if you have ever had the following. If you are not sure, do not answer the question.

Heart/Blood Vessels

Rheumatic Fever	Yes	No
Rheumatic Heart Disease	Yes	No
Heart Valve Damage	Yes	No
Heart Murmur	Yes	No
Congenital Heart Defect	Yes	No
Artificial Heart Valve	Yes	No
Prolapsed Heart Valve	Yes	No
Do you Pre-Medicate for Dental Appointments?	Yes	No
High Blood Pressure	Yes	No
Heart Attack – Date _____		No
Stroke/TIA – Date _____		No
Heart Surgery – Date _____		No
Vascular Surgery – Date _____		No
Pacemaker	Yes	No
Coronary Heart Failure	Yes	No
Congestive Heart Failure	Yes	No
Angina / Chest Pain	Yes	No
Irregular/ Rapid Heart Beat	Yes	No

Other Heart/Vessel Disorder_____

Blood

Blood Clots/ Thrombosis	Yes	No
Anemia	Yes	No
Sickle Cell Disease/ Trait	Yes	No
Hemophilia	Yes	No
Transfusion – Date _____		No
Bruise Easily w/No Reason	Yes	No

Other Blood Disorder _____

Nervous System

Epilepsy	Yes	No
Seizure Disorder	Yes	No
Multiple Sclerosis	Yes	No
Trigeminal Neuralgia	Yes	No
Chronic Pain	Yes	No
Anxiety/ Depression	Yes	No
Alzheimer's or Dementia	Yes	No
Psychiatric Treatment	Yes	No
Psychological Counseling	Yes	No
Persistent Dizziness/ Fainting	Yes	No
Persistent Numbness/Tingling	Yes	No

Other Nervous/ Mental Disorders?

_____

Head & Neck

Glaucoma	Yes	No
Chronic Sinusitis	Yes	No
Injury to Head, Neck, Jaw Or Teeth	Yes	No
Headaches	Yes	No
Unexplained Visual Change	Yes	No
Frequent/ Severe Nosebleeds	Yes	No
Persistent Sore Throat Or Hoarseness	Yes	No
Recurrent Neck Ache/ Pain	Yes	No
Recent Difficulty Swallowing	Yes	No

Other Head/ Neck Disorder_____

Endocrine

Diabetes	Yes	No
Low Thyroid	Yes	No
Other Thyroid Condition	Yes	No
Cushings Syndrome	Yes	No
Parathyroid Condition	Yes	No

Other Endocrine Condition_____

Musculoskeletal/ Connective Tissue

Sjogren's Syndrome	Yes	No
Arthritis	Yes	No
Artificial Joint – Date _____		No
Fibromyalgia/ Rheumatism	Yes	No
Chronic Back pain	Yes	No

Other Muscle/ Bone Disorder_____

Respiratory

Tuberculosis (TB)	Yes	No
Asthma	Yes	No
Chronic Bronchitis	Yes	No
Emphysema	Yes	No
Persistent Cough	Yes	No
Coughing Bloody Sputum	Yes	No
Shortness of Breath	Yes	No
Other Respiratory Disorder	Yes	No

Urinary Tract

Kidney Disease	Yes	No
Renal Dialysis	Yes	No
Venereal Disease	Yes	No
Sexually Transmitted Disease	Yes	No

Other Urinary Disorders _____

Digestive System

Hepatitis	Yes	No
Cirrhosis of the Liver or Liver Disease	Yes	No
Ulcers	Yes	No
Jaundice	Yes	No
Frequent Heartburn/ Reflux	Yes	No
Frequent Nausea/ Vomiting	Yes	No

Other Digestive Disorder_____

Cancer History

Cancer	Yes	No

Type_____

Leukemia	Yes	No
Benign Tumors/ Growths	Yes	No
Type of Treatment:		
Surgery	Yes	No
Radiation	Yes	No
Chemotherapy	Yes	No
Hormone Therapy	Yes	No

Allergy History

Are you allergic or have you ever had a bad reaction to any of the following?

Dental Anesthetics	Yes	No
Penicillin	Yes	No
Sulfa Drugs	Yes	No
Other Antibiotics	Yes	No
Aspirin	Yes	No
Latex Products	Yes	No
Metals, including jewelry	Yes	No

Other Allergy_____

Family History

Has anyone in your family (grandparent, parent, sibling, child) ever had:

Diabetes	Yes	No
Heart Disease	Yes	No
Depression/ Anxiety	Yes	No
Tuberculosis	Yes	No

Any other disorders that run in your family?

_____

_____

Health History Continued…

Please circle yes if you have ever had the following. If you are not sure, do not answer the question.

Miscellaneous

Lupus Erythematosus Yes No
Organ Transplant Yes No
Which organ? _____
Suppressed Immune System Yes No
Persistent Fever Yes No
Taken Steroid/ Prednisone Yes No
Tested Positive for HIV Yes No
Diagnosed with AIDS Yes No
Taken Prescription Diet Pills Yes No
What Type:
□ Pondimin □ Phen-fen
□ Redux □ Other _____

Miscellaneous

Have you ever:
Used tobacco products? Yes No
What Type? _____
How Much? _____
How Long? _____
Still Using Tobacco? Yes No
Do you want to quit? Yes No
Consumed alcohol? Yes No
How often? _____
Used Methamphetamine, Amphetamines, or Speed? Yes No
Used Intravenous Drugs? Yes No
Used Cocaine or Crack? Yes No

Miscellaneous

Used any other Recreational drugs? Yes No
Are you a recovering alcholic or addict? Yes No

Women Only

Are you pregnant or possibly pregnant? Yes No
Due Date? _____
Are you breast feeding? Yes No
Are you in or have you passed through menopause? Yes No

Do you or have you ever Pre-medicated for dental appointments? Yes No
Why? _____ Which antibiotic? _____

Are there any other conditions you think we should know about? _____
_____

***Please circle all the medications you are currently taking:

Heart	Blood Thinners	Hormones	Antibiotics	Tranquilizers
Nitroglycerin	Blood Pressure	Insulin/Diabetic Drugs	Antihistamine	Antidepressants
Digitalis	Oral Contraceptive	Thyroid	Cyclosporine A	Pain
Aspirin ____ Tabs/Day	Steroids/Cortisone	Nifedipine		

List medication names and dosages. Include over-the-counter, herbal and nutritional supplements:

_____ _____
_____ _____
_____ _____
_____ _____

***The information I have provided here is an accurate statement of my health history.
I have disclosed any and all health information that I am aware of.

_____ _____
Signature of Patient, Parent or Guardian Date Signature of Reviewing Doctor Date

Health Updates *(To be completed every 6 months; more as indicated)*

Date	Changes	Patient Initials	Doctor Initials