HEALTH QUESTIONNAIRE

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PLEASE PRINT

Date_____

Name_____
Mr. / Mrs. / Miss / Child / Dr.

CIRCLE and/or **ANSWER** each question.

1. Are you presently, or have you recently been experiencing pain in your mouth or face?.....Yes No
2. Do you consider your general health to be good.....Yes No
3. What is the name of your medical doctor?

   _____
4. Are you being treated by a physician now?.....Yes No
   What is the treatment for?_____
5. Do you take aspirin or a blood thinner on a regular basis? What?_____Yes No
6. List any medications or drugs you take regularly:

   _____
7. Have you ever had any of the following?
   - Heart Attack .....Yes No
   - By Pass surgery / Pace maker.....Yes No
   - Stents.....Yes No
   - Heart Disease..... Yes No
   - Mitral Valve Prolapse.....Yes No
   - Heart Murmur .....Yes No
   - Rheumatic Fever.....Yes No
   - High Blood Pressure.....Yes No
   - Low Blood Pressure.....Yes No
   - Are you Diabetic?.....Yes No
   - Family History of Diabetes.....Yes No
   - Joint replacement or artificial prosthesis (ie.hip, knee, etc.).....Yes No
   - Lung trouble / TB.....Yes No
   - Cancer..... ....Yes No
   - Radiation treatment.....Yes No
   - Chemotherapy treatment.....Yes No
   - Blood disease.....Yes No
   - Diagnosed HIV Positive.....Yes No
   - Do you have AIDS?.....Yes No
   - Prolonged bleeding/ Bleed easily.....Yes No
   - Prostate problems..... Yes No
   - Kidney / Bladder trouble.....Yes No
   - Hepatitis A, B or C .....Yes No
   - Jaundice or liver disease.....Yes No
8. Do you have any allergies? (ie. hayfever, asthma latex, iodine, etc.).....Yes No
9. Are there any **medicines** (such as aspirin, penicillin, codeine, barbiturates) that you can <u>not</u> take?.....Yes No
   Which one(s)?_____
10. Did you or have you ever taken Biphosphonate drugs like Fosamax, Actonel, Skelid, Aredia, Fometa, Boniva, etc.....Yes No
11. Do your gums bleed?.....Yes No
12. When did you last have your teeth cleaned?_____
    How frequently in the last 10 years?_____
13. Have you noticed any loose teeth?.....Yes No
14. Have you noticed any bad odors or tastes from your mouth?.....Yes No
    For how long?_____
15. Have you ever had periodontal (gum) treatment?....Yes No
    When?_____
    What type of treatment?_____
16. Approximate date of last tooth extraction._____
17. Are your teeth sensitive to cold, hot or sweets?.....Yes No
18. Do you ever have pain in the region in front of your ears? (Jaw joint pain).....Yes No
19. Would you be greatly disturbed if you had to lose all your teeth?.....Yes No
20. Do you use tobacco products?.....Yes No
    What kind?_____
    How often?_____
    How long?_____
21. WOMEN:
    Are you pregnant?.....Yes No
    Have you passed menopause (change of life)?.....Yes No

(X)_____
Patient's Signature .

_____
Doctor's Signature