

HEALTH QUESTIONNAIRE

James W. Betancourt, DMD, MS

PLEASE PRINT

Name _____
Mr. / Mrs. / Miss / Child / Dr.

Date _____

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 not 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