Health Questionnaire

Date_____

Last Name_____First Name_____MI._____Prefer to be called_____

Social Security No._____Birth Date_____

Address_____
(Street Address)

_____Email address_____
(City) (State) (Zip Code)

Email Reminder: Yes or No Text Reminder: Yes or No
Preferred Method of Contact: Home Phone or Cell Phone or Email or Other

Home Phone_____Business Phone_____Cell Phone_____

Occupation_____Employer_____

Do you have Dental Insurance?_____Who referred you to this office?_____

Please answer each question below by circling yes or no:

1. Have you been under the care of a physician? Yes No
(If yes please explain)_____

2. Have you had a serious illness, operation, or hospitalization in the past 5 years? Yes No
(If yes please explain)_____

3. Are you currently taking any drugs or medications? Yes No
(If yes please list all and why)_____

4. Have you had surgery requiring you to take antibiotics before dental procedures? Yes No

5. Have you ever taken Bisphosphonate drugs IV or orally? Yes No
(ex. Fosamax, Aredia, Actonel, Zometa, Boniva)

6. Are you allergic to any drugs? Yes No
(If yes please indicate)_____

7. Have you ever had excessive bleeding requiring special treatment? Yes No

8. Have you tested positive for AIDS (HIV virus) or had any exposure to AIDS? Yes No

9. Circle any of the following which you have had:

angina (chest pain)	rheumatic/scarlet fever	liver disease	anemia	epilepsy
artificial heart valve	stroke	thyroid disease	blood disorders	cancer
pacemaker	diabetes	asthma	arthritis	chemotherapy
high blood pressure	hepatitis A/B/C	sinus problems	artificial joints	radiation
heart surgery	kidney disease	tuberculosis	fainting	

10. List any other serious illness not included above_____

11. Women only – Are you now pregnant?_____(If yes, please indicate due date)_____

12. Have you experienced any growths or sore spots in your mouth? Yes No

13. Have you ever had prolonged bleeding following extractions? Yes No

14. Do your gums bleed? Yes No

15. Have you had prior instruction as to brush and floss correctly? Yes No

16. Do you smoke or chew tobacco? Yes No
If yes how much and how long _____

17. Is any part of your mouth currently sore? Yes No
(If yes please indicate where)_____

18. On a scale of 1-10, with 10 being the highest rating, rate your smile_____ rate where you'd like it to be _____

19. Please circle what you would like to change about your smile if anything

color crowding bite chipped teeth missing teeth spaces whiter teeth

SIGNATURE_____