HEALTH QUESTIONNAIRE

Last Name _____ First Name_____ Middle Initial_____

MEDICAL HEALTH INFORMATION

How is your general overall health? EXCELLENT GOOD FAIR POOR
Are you presently under medical care for a disease, condition or illness? Please explain _____
Who is your primary care physician? _____ Address _____ Phone ( )_____
When was your last physical examination, and what were the results? _____
Are you now or have you recently been taking any medications either prescribed or over-the-counter? Please list the medications and explain_____
Are you allergic, sensitive to or avoid any drugs or medications? Please explain _____
Do you have any difficulty with bleeding or healing from a cut, wound or extraction? _____
Do you smoke, vape or chew tobacco?_____
Women: Do you suspect or are you pregnant? If yes, how many months?_____
Are you taking birth control pills? Y N
Do you have or have you ever had any of the following diseases, illnesses or health issues? PLEASE CIRCLE

Heart murmur/ Mitral valve prolapse	Psychiatric or Psychological care	Gastrointestinal disease
Rheumatic fever/ Congenital heart disease	Neurological disorders	Glaucoma
Heart surgery, disease, attack, pacemaker	Nervous or Anxious tendencies	Hepatitis
Coronary occlusion/ Stroke	Fainting/ Dizzy spells	Kidney disease
Artificial heart valve	Epilepsy/ Seizures / Confusion	Liver disease/ Jaundice
Hip or knee joint replacement	Chemotherapy/ Radiation	Lung disease/Asthma/TB/Emphysema
High or low blood pressure	Bisphosphonate drug treatments	Respiratory problems
Blood disease/ Anemia	Allergies	Thyroid disease
HIV / AIDS / COVID-19	Latex allergy	Venereal disease
Tumors, growths, cancer	Arthritis/ Rheumatism	Drug or alcohol abuse/ Dependency
Blood transfusions	Osteoporosis	Diabetes
Shortness of breath, Fever, Cough, Sneezing	Body/ Headache/ Fever/ Tired	Loss of taste or smell

Use this space or write on the back for additional information, dates, explanations, list of meds, specialists, etc._____
_____

DENTAL HEALTH INFORMATION

What is the reason for your visit today? _____
When was your last dental visit and x-rays? _____ What was done?_____
Is there anything about dental treatment that concerns you?_____
Do you have any pain, lumps or infections in your mouth. Are there any other concerns or problems that require attention, immediate or otherwise? _____
Have you ever had periodontal (gum or bone) treatment? _____
Do your gums bleed, when you brush or floss? Do you floss?_____
Are any of your teeth sensitive to pressure, temperatures or sweets? Please locate _____
Are there any areas where food collects or dental floss constantly gets stuck? Please locate _____
Are you dissatisfied with the appearance or alignment of your teeth? Please explain _____
Are you concerned about the presence of bad breath or a foul taste? _____
Do you grind your teeth either occasionally or frequently? _____
Have you experienced clicking or popping noises in your jaw joint, pain or difficulty in opening or closing your mouth?
_____
Have you noticed any loose teeth or differences in your bite?_____
Have you ever had reactions or adverse symptoms to ‘novacaine’ or other anesthetics? _____

CONSENT TO THE RELEASE OF INFORMATION

I certify that I have answered all of the aforementioned health questions to the very best of my knowledge. In the future, I will advise Dr. Share or the dental staff of any changes in my physical condition or health history. I give this dental office the right to release any health information and x-rays (your Protected Health Information) relevant to my treatment to my insurance carrier(s), physician(s) or dental specialist(s) that I may be referred to.

SIGNATURE _____ DATE_____