DENTAL HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your dental record.

Name:			**Date of Birth:**	

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING

Yes	No	AIDS/HIV
Yes	No	Arthritis OR Cortisone Treatments
Yes	No	Artificial Joint If Yes, list of joint(s) involved:
Yes	No	Back Problems
Yes	No	Chemical Dependency
Yes	No	Headaches
Yes	No	Excessive Bleeding
Yes	No	Fainting or Dizziness
Yes	No	Diabetes
Yes	No	Anemia
Yes	No	Kidney Disease
Yes	No	Sexually Transmitted Disease
Yes	No	Psychological Disorder or Treatment
Yes	No	Heart Disease OR Congenital Heart Defect
Yes	No	Aneurism OR Heart Attack OR Stroke
Yes	No	Stents OR Pacemaker OR Artificial Valves in Heart
Yes	No	Cancer If yes, list type of cancer and treatment received:
Yes	No	Glaucoma
Yes	No	Seizures OR Epilepsy
Yes	No	Lung Disease
Yes	No	Asthma OR COPD OR Shortness of Breath
Yes	No	Tuberculosis
Yes	No	Bloody OR Persistent Cough
Yes	No	High Blood Pressure
Yes	No	Liver Disease
Yes	No	Thyroid Disease

WOMEN

Yes	No	Are you pregnant?
Yes	No	Are you nursing?

List your prescribed drugs and over-the-the-counter drugs, such as vitamins and inhalers.

List any allergies to medications.

OTHER CONDITIONS

List any other medical problems/conditions that were NOT mentioned above:

HEALTH HABITS

Tobacco	Do you use tobacco or an electronic cigarette?		Yes		No
	Cigarettes – pks./day	Chew - #/day	Pipe - #/day	Cigars - #/day	
	# of years	Or year quit			

Preferred Pharmacy:______________________________Date:___________________________MRN:________________

Patient/Parent/Guardian Signature:____

Dentist Signature:____ASA Number:___________________________