HEALTH QUESTIONNAIRE
[All information is kept confidental]

Name____
Last First Middle

Do you have any dental problems or pain at this time? _________________________
____

Do you have any general health problems? ___________________________________
____

What medications are you taking?____
____

What vitamins, minerals and herbs are you taking? _____________________________
____

Have you-ever been hospitalized?
If yes, please specify. ____
____

Are you under a physician's care?
Physician's name__________________ Physician's phone number ___________________________

Please check each of the following **that apply**. Do you have or have you ever had or been advised of any of the following?:

Acid Reflux/GERD___________
Allergies__________________
Anemia_____________________
Artificial Joint____________
Pre Med Rx required ____Yes _____No
Asthma ____________________
Back Problems_______________
Blood Disorder______________
Blood Thinner Rx____________
Cholestrol Problem_____
Cancer ____________________
Cough, Persistent___________
Diabetes____________________
Drug Dependency_____________

Epilepsy, Seizure ___________
Glaucoma____________________
Headaches___________________
Heart Problems_______________
Describe__________________
Hepatitis___________________
High Blood Pressure _________
Jaw Pain____________________
Kidney Disease_______________
Liver Disease_______________

Lung Disease_________________
Nervous Disorder_____________
Psychiatric care_____________
Pre Med Rx –Specify__________
Sleep Apnea__________________
Stroke_______________________
Surgical Implant_____________
What Kind?_______________
Tuberculosis_________________
Thyroid______________________
Ulcers_______________________
Venereal Disease_____________

Do you use antacids on a regular basis?

Do you get cold sores or canker sores?

Do you get shingles?

Do you use tobacco?

Allergies to Medications:
Penicillin_________
Novacaine _________
Epinephrine _______
Other______________

Sulfa _____________
Codeine ___________

Allergies to Food:____

Other Allergies:____
WOMEN ONLY

Are you pregnant or think you may be pregnant? _______

Are you nursing? ____________

Are you taking birth control pills? ________

(If the need for antibiotics arises, you need to know that they decrease the effectiveness of some types of birth control pills.)