# Monroe Dental Clinic

## Health Questionnaire

*Please Print*

| Today's Date | Patient's Name | Sex | Birthdate |
|---|---|---|---|
| ___/___/_____ | _____________________ | ☐ Male ☐ Female | ___/___/_____ |

***Name of person competing form (if different from patient) and relation to patient:***

_______________________________________ _______________________

*Printed Name* *Relation*

*Please answer the following questions to the best of your ability, realizing that true and accurate answers are important to the delivery of quality care.* ***<u>All information you provide will be kept confidential</u>****.*

**Please Answer By Circling Yes(Y) Or No(N) For Each Individual Question.**

| Question | Y | N |
|---|---|---|
| 1. Are you in good health? | Y | N |
| 2. Has there been any change in your general health in the past years? | Y | N |
| 3. Date of last check up by physician : ____________ | | |
| 4. Are you currently under a physician's care | Y | N |
| If so, what for? ____________ | | |
| Treating Physician's Name: ____________ Phone Number: ____________ | | |
| 5. Have you had any serious illness, operations, or hospitalizations? | Y | N |
| If so, describe and give approximate dates: ____________ | | |
| ____________ | | |
| ____________ | | |
| 6. Have you ever has intravenous sedation or general anesthesia? | Y | N |
| 7. Do you generally tolerate dental treatment well? | Y | N |
| 8. Do you have or have your ever had: | | |
| A. Heart disease that was detected at birth? | Y | N |
| B. Rheumatic fever or Rheumatic heart disease? | Y | N |
| C. Cardiovascular disease (chest pain, heart trouble, heart attack, coronary artery disease, high blood pressure, stroke, palpitations, heart surgery, angioplasty, pacemaker)? | Y | N |
| D. Lung disease (asthma, emphysema, chronic cough, bronchitis, pneumonia, TB, shortness of breath, severe cough)? | Y | N |
| E. Neurologic disorder (seizure, epilepsy, fainting, dizziness, nervous disorder)? | Y | N |
| F. Blood disease (bleeding disorder, anemia, blood transfusion, do you bruise easily)? | Y | N |
| G. Liver disease (jaundice, hepatitis)? | Y | N |
| H. Kidney disease? | Y | N |
| I. Diabetes? | Y | N |
| J. Thyroid disease (hypothyroidism, tumor)? | Y | N |
| K. Arthritis? If so, which joints? ____________ | | |
| L. Stomach ulcers or intestinal problems? | Y | N |
| M. Glaucoma? | Y | N |
| N. Frequent or recurring mouth sores? | Y | N |
| O. Implants/ artificial joints anywhere in your body? ( heart valve, hip, knee)? | Y | N |
| P. Radiation (X-ray treatment for cancer) in head or neck region? | Y | N |
| Q. Noises in jaw joint, pain near ear when chewing, do you grind or clench teeth? | Y | N |
| R. Sinus or nasal problems? | Y | N |
| S. Any disease, drug, transplant, operation or HIV that has depressed your immune system? | Y | N |
| T. Recurrent infections of any kind? | Y | N |

***Please continue on other side of form***

9. Are you taking or using any of the following? Y | N

A. Antibiotics? .......... Y | N
B. Anticoagulants (blood thinners)? .......... Y | N
C. Thyroid medication? .......... Y | N
D. Antihistamines, Decongestants? .......... Y | N
E. High blood pressure or heart? .......... Y | N
F. Steroids? .......... Y | N
G. Tranquilizers, Antidepressants? .......... Y | N
H. Stomach or GI medications( anacids,etc)? .......... Y | N
I. Cholesterol reducing drugs? .......... Y | N
J. Aspirins, ibuprofen, NSAIDS, or anti-inflammatory drugs,(narcotics, opioids, or other pain relievers)? .......... Y | N
K. Weight reduction pills of diet aids( over the counter or "natural" products? .......... Y | N
L. Vitamins, natural remedies( ginko biloda, ephedra, ginseng,etc.) or other supplements? .......... Y | N
M. Marijuana, cocaine, or other "recreational"drugs? .......... Y | N
N. Any other regular medications, pills, supplements or drugs? .......... Y | N

**Please list all current medications here:**____________________

____________________

____________________

10. Are you allergic to or had a bad reaction from:

A. Local anesthetic(Novacain-like drugs)? ..... Y | N
B. Penicillin, amoxicillin, cephalosporins? ..... Y | N
C. Other antibiotics? .......... Y | N
D. Barbiturates, sedatives? .......... Y | N
E. Aspirin, ibuprofen, NAIDS or other pain medicines? .......... Y | N
F. Codeine or other narcotics or opioids? .. Y | N
G. Latex? .......... Y | N
H. Other allergies or reactions? .......... Y | N
Please list:____________________

____________________

____________________

11. Do you have hay fever, frequent skin rashes, etc? .......... Y | N
12. Do you use alcohol? How much per day?____________________
13. Do you smoke? .......... Y | N
What product and how many per day?____________ For how long?____________
14. Do you split tobacco? .......... For how long?____________
15. Are you, or have you been, in a drug or alcohol recovery program? .......... Y | N
16. Do you have any other disease, condition or problem not listed that you think the doctor should know about?.
17. Do you wish to talk to the doctor privately about anything? .......... Y | N
18. Any additional comments?____________________

19. **Women**

A. Are you taking birth control pills? .......... Y | N
B. Are you pregnant, trying to become pregnant or any chance you might be pregnant? .......... Y | N
C. Are you BREAST FEEDING? .......... Y | N
D. Are you taking hormonal replacement? .......... Y | N

**I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.**

__________ Date

____________________ Signature of person completing Health Questionnaire

Doctor's Initials

**Thank you. Do not write below this line.**

| **Medical Updates:** *Reviewed by* | **Medical Updates:** *Reviewed by* | **Medical Updates:** *Reviewed by* | **Medical Updates:** *Reviewed by* | **Medical Updates:** *Reviewed by* |
|---|---|---|---|---|
| Dr.______ | Dr.______ | Dr.______ | Dr.______ | Dr.______ |
| Date______ | Date______ | Date______ | Date______ | Date______ |