Health Questionnaire

Patient's Name: _____ **Date of Birth: _____**

Physician Name: _____ **Latex Allergy:** YES or NO
Physician Phone Number: _____ (Please Circle)

Have you ever had or do you have now: (Please check the appropriate box)

Check each item	Yes	No	Unknown		Yes	No	Unknown		Yes	No	Unknown
Epilepsy or Seizures				Hemophilia				Kidney Problems			
Fainting or Dizziness				Bleed Easily				Diabetes			
Nervousness				Heart Attack				Thyroid Disease			
Stroke				Heart Problems				HIV +			
Glaucoma				High Blood Pressure				Arthritis			
Cold Sores (Herpes)				Rheumatic Fever				Painful Joints (jaw?)			
Persistent Cough				Heart Murmur				Prosthetic Joints			
Emphysema				Mitral Valve Prolapse				Hives			
Tuberculosis				Congenital Heart Lesions				Steroid Medications			
PPD Positive				Heart Surgery				Drug Addiction			
Asthma				Prosthetic Heart Valves				Alcoholism			
Hay Fever				Pacemaker				Weight Change			
Sinus Problems				Blood Transfusion				Cancer/Radiation			
Anemia				Liver Disease				Hepatitis Type ____			
Sickle Cell Disease				Yellow Jaundice				Venereal Disease			
G6PD Deficiency				Ulcers				Angina			

Please Answer ALL of the Following Questions:

1. Have you ever been told that you require antibiotics prior to dental treatment? _____ (If yes, Why?): _____

2. Have you ever been diagnosed with Obstructive Sleep Apnea? _____ (If Yes, Do you currently use a CPAP?): _____

3. Do you have a disease or condition not mentioned above? _____ (If Yes, please explain): _____

4. Have you ever been told that you should not donate blood? _____

5. Are you ill or currently under the care of a physician? _____ (If Yes, please describe): _____

Females: 6. Are you taking birth control pills? _____

7. Are you pregnant? _____

8. Are you breast feeding? _____

History of Hospitalizations:

List ALL Medications you are currently taking:
(use back of sheet if needed)

List ALL Allergies:

If you answered "YES" to any of the above, please explain:

Please Sign and Date (*ONCE*) Below After Updating:

Patient's Signature	Date	Doctor's Signature	Date
Patient's Signature	Date	Doctor's Signature	Date
Patient's Signature	Date	Doctor's Signature	Date
Patient's Signature	Date	Doctor's Signature	Date
Patient's Signature	Date	Doctor's Signature	Date