Health Questionnaire

Name ____ Date ________________

Have you been under a physician's regular care during the past 2 years? Yes ☐ No ☐

If yes, reason for treatments: ____

Name of Physician: ____

Name of General Dentist: ____

Does your treatment require you to be **pre-medicated** (antibiotics <u>before</u> treatment)? Yes ☐ No ☐

Have you been hospitalized for any *<u>serious</u>* illness, surgery or other condition? Yes ☐ No ☐

If yes, please list: ____

Are you currently taking any medications? Yes ☐ No ☐
Please list all medications you're taking:

____

Please check any of the following illnesses or conditions that affect you:

- ☐ Rheumatic Fever
- ☐ Heart Murmur
- ☐ Heart Disease or Attack
- ☐ High Blood Pressure
- ☐ Chest Pains
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Epilepsy
- ☐ Hepatitis or Jaundice
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Bronchitis History
- ☐ Tuberculosis
- ☐ Diabetes
- ☐ Cancer or Tumor
- ☐ Glaucoma
- ☐ Kidney Disease
- ☐ Lung Disease
- ☐ Radiation Treatment
- ☐ High Risk Group for HIV
- ☐ Depression
- ☐ Emotional Disorder
- ☐ Fibromyalgia
- ☐ Dizziness or Fainting
- ☐ Chemical Dependency
- ☐ Any disease that has suppressed your immune system
- ☐ Liver Disease
- ☐ Tobacco User
  Smoke?☐ Chew?☐
  How much?
  ____
- ☐ Taking Blood Thinners
  Coumadin, Warfarin, Plavix, Aspirin or others
- ☐ WOMEN: Pregnant or Nursing?

ALLERGIES
Are you allergic to or had an adverse reaction to Penicillin, sedatives, barbiturates, ibuprofen, latex and/or rubber products, codeine or other pain killers? Yes ☐ No ☐
Allergies or reactions, please list: ____

Ever had any adverse reaction to Local Anesthetics (Lidocaine) or General Anesthesia? Yes ☐ No ☐

General Anesthesia patients: Have you had anything to eat or drink in the past 6 hours? Yes ☐ No ☐

SIGNED ____ Date ________________