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dentalcare.com

Health History Questionnaire

Your health history is very important to us. In order that we may provide you with the best possible dental services, please answer all questions completely and accurately as incorrect information may compromise your treatment. This Health History Questionnaire will become a part of your dental treatment record and is considered "Confidential."

Date _____

Last Name _____ **First Name** _____ ☐ **Dr.** ☐ **Mr.** ☐ **Mrs.** ☐ **Ms.**

Address _____

City _____ **State** _____ **Zip** _____

Reason for today's visit: (circle) Examination/Cleaning Pain/Swelling Broken Tooth/Filling

Have you previously been treated for this problem or concern? (circle) Yes No

How long has this been a problem or concern? _____

Health History

Are you currently under the care of a physician? (circle) Yes No

Reason for last visit? _____

Date of last physical examination _____/_____/_____

Physician's Name _____ **Phone** (_____)_____

Address _____

City _____ **State** _____ **Zip** _____

Past Medical History

1. **Have you ever had a serious illness, operation, or been hospitalized?** If so, please explain:
   _____

2. **Has there been any change in your health in the last two (2) years?** (circle) Yes No
   If yes, please explain _____

3. **Have you ever had an allergic reaction?** To: (circle) Medication Food Latex Products
   Other: _____

4. **Have you ever had or been treated for:** (circle all that apply):

Blood Pressure: High or Low	High Cholesterol	Heart Disease	Stroke
Rheumatic Fever	Heart Murmur	Heart Valve	Fibromyalgia
Hepatitis	Diabetes	Depression	Tuberculosis
Immunocompromised Disease	Asthma	Bleeding/Clotting Disorder	Dry Mouth
Other:			

5. **Do you now or have you ever used tobacco?** (circle) Yes No
   If you currently use tobacco, are you interested in quitting? (circle) Yes No

6. **How many alcoholic drinks do you consume:** a day? _____ a week? _____ a month?_____

7. **For women:** **a. Are you pregnant or do you think you may be pregnant?** (circle) Yes No
   b. Are you taking birth control pills? (circle) Yes No

Current Medications: Prescribed and Over-the-Counter

	Name of Medication	Dose	Frequency
1.			
2.			
3.			