

HEALTH QUESTIONNAIRE
[All information is kept confidential]

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 _____	Epilepsy, Seizure _____	Lung Disease _____
Allergies _____	Glaucoma _____	Nervous Disorder _____
Anemia _____	Headaches _____	Psychiatric care _____
Artificial Joint _____		Pre Med Rx -Specify _____
Pre Med Rx required ___Yes ___No		Sleep Apnea _____
Asthma _____		Stroke _____
Back Problems _____	Heart Problems _____	Surgical Implant _____
Blood Disorder _____	Describe _____	What Kind? _____
Blood Thinner Rx _____	Hepatitis _____	Tuberculosis _____
Cholesterol Problem _____		Thyroid _____
Cancer _____	High Blood Pressure _____	Ulcers _____
Cough, Persistent _____	Jaw Pain _____	Venereal Disease _____
Diabetes _____	Kidney Disease _____	
Drug Dependency _____	Liver 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 _____	Sulfa _____
Novacaine _____	Codeine _____
Epinephrine _____	
Other _____	

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.)