Health Questionnaire

Name: _____ _____**Date:** _____

Address: _____**City:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____ **Birth Date:** _____

Marital Status: Married_____ **Single:** _____ **Other:** _____ **Social Security Number:** _____

Employer: _____ **Would you like to receive text message as a reminder for next appointment: Yes:** ___**No:** ____

Please list all medications presently taking. Please include all prescribed and over the counter medications including supplements

_____

_____

_____

Date of your last physical _____ **Please check all of the following that apply to you:**

- ☐ Allergic to Chemicals
- ☐ Allergic to Dyes
- ☐ Allergic to Latex
- ☐ Allergic to Metals
- ☐ Allergies to Medications
  _____
  _____
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Aspirin
- ☐ Asthma
- ☐ Bacterial Endocarditis
- ☐ Blood Disease
- ☐ Blood Thinner (see below)
- ☐ Cancer (see below)
- ☐ Cardiomyopathy
- ☐ Cholesterol
- ☐ Defibrillator/Pacemaker
- ☐ Diabetes Type_____
- ☐ ___Dizziness ___Fainting ___Seizures
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Heart Murmur
- ☐ Heart Problems _____
- ☐ Heart Valve Replacement
- ☐ Hemophilia
- ☐ Hepatitis Type_____
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ HPV Vaccine
- ☐ Implants of any kind
  _____
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ Osteoporosis
- ☐ Pregnant
- ☐ Pulmonary Shunts
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever/Scarlet Fever
- ☐ Rheumatic Heart Disease
- ☐ Rheumatism
- ☐ Severe Headaches
- ☐ Sinus Problems
- ☐ Stent-Type_____
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Swollen Ankles
- ☐ TMJ Problems
- ☐ Thyroid
- ☐ Tobacco Products/How Much? _____
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Any other important information_____
  _____
  _____

Have you taken any of the following blood thinners in the last five days? Heparin, Warfarin (Coumadin, Jantoven), Dabigatvan Etexilate (Pradaxa), Rivaroaban (Xarelto), Aspirin, Cilostazol (Pletal), Clopidogrel (Plavix), Dipyridamole (Persatinc), Prasugrel (Effient), Ticagrelor (Brilinta), Ticlopidine (Ticlid). _____Yes ____ No, if yes, please circle which one.

Are you or have you been on any of the following drugs in the past? Aredia, Actonel, Bonivia, Didronel, Evista, Fosamax, Prolla, Reclast, Skelid, and Zometa? ___Yes ___No if yes, please circle which one. Date started & stopped _____

If you have or had any type of cancer please answer the following: When: _____ **Chemo?** ___**Yes**___**No Radiation?** ___**Yes**___**N0**
Where was cancer located: _____

Have you been told you need antibiotics before dental treatment? _____Yes _____No, if yes What for? _____

Have you had any type of surgery within the last two years? _____Yes _____No.

If yes, please explain: _____

Family Doctor: _____ **Phone:** _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes in my health, I will inform the doctors at the next appointment without fail.

Signature: _____ **Date:** _____