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 (daily)
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Thinner (see below)
- ☐ Cancer (see below)
- ☐ Cholesterol
- ☐ Defibrillator/Pacemaker
- ☐ Diabetes Type_____
- ☐ ___Dizziness ___Fainting ___Seizures
- ☐ Dialysis
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ G.E.R.D.
- ☐ Glaucoma
- ☐ Heart Problems _____
  __major cyanotic heart disease
  __Previous bacterial Endocarditis/infective
  __Prosthetic heart valve Replacement
  __Ventricular defect after Heart repair
  __Repaired congenital heart Disease with prosthetic Materials (first 6 months)
- ☐ Hemophilia
- ☐ Hepatitis Type_____
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Implants of any kind
  _____
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Osteoporosis
- ☐ Pregnant – how far along_____
- ☐ Pulmonary shunts
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ 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), Apixaban (Eliquis). _____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, 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: _____