HEALTH QUESTIONNAIRE

Name _____ Birth date _____

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Circle yes or no, whichever applies, in response to the following questions. Your answers are for our records only and will be considered confidential.

DENTAL

1. Are you having any discomfort at this time ..... Yes No
2. Have you ever had any serious trouble associated with previous dental treatment? ..... Yes No
   If so explain? _____
3. Does dental treatment make you nervous? No _____ Slightly _____ Moderately _____ Extremely _____
4. Date of last dental visit _____
5. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? ..... Yes No
   If so when? _____
6. How often do you brush _____
   Brush is: Soft ☐ Medium ☐ Hard ☐
7. Do you have or have you ever had any of the following?

MOUTH

Bleeding, sore gums	Yes	No
Unpleasant taste/bad breath	Yes	No
Burning tongue/lips	Yes	No
Frequent blisters, lip/mouth	Yes	No
Swelling/lumps in mouth	Yes	No
Ortho treatments (braces)	Yes	No
Biting cheeks/lips	Yes	No
Clicking/popping jaw	Yes	No
Difficulty opening or closing jaw	Yes	No

TEETH

Loose teeth	Yes	No
Sensitive to hot	Yes	No
Sensitive to cold	Yes	No
Sensitive to sweets	Yes	No
Sensitive to biting	Yes	No
Food impaction	Yes	No
Clenching/grinding	Yes	No
If so, when _____		
Shifting in bite	Yes	No
Change in bite	Yes	No

8. Do you use the following?

Brush	Yes	No
Dental floss	Yes	No
Fluoride rinse	Yes	No

Other _____

MEDICAL

1. Has there been any change in your general health within the past year ..... Yes No
2. My last physical examination was on _____
3. Are you now under the care of a physician ..... Yes No
   If so, what is the condition being treated _____
4. The name and address of my physician is _____
   _____
5. Have you had any serious illness within the past five (5) years ..... Yes No
   If so, what was the illness _____
6. Have you been hospitalized or had an operation within the past five (5) years ..... Yes No
   If so, what was the problem _____
7. Do you have or have you had any of the following diseases or problems
   a. Rheumatic fever or rheumatic heart disease ..... Yes No
   b. Congenital heart disease ..... Yes No
   c. Cardiovascular disease (heart trouble, heart attack, heart murmur, coronary insufficiency, coronary occlusion, high/low blood pressure, arteriosclerosis, stroke, etc.) ..... Yes No
      1) Do you have pain in chest upon exertion ..... Yes No
      2) Are you ever short of breath after mild exercise ..... Yes No
      3) Do your ankles swell ..... Yes No
      4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep ..... Yes No
   d. Artificial or replacement valves ..... Yes No
   e. Pacemaker ..... Yes No
   f. Allergy ..... Yes No
   g. Sinus trouble ..... Yes No
   h. Asthma or hay fever ..... Yes No
   i. Hives or a skin rash ..... Yes No
   j. Fainting spells or seizures ..... Yes No
   k. Diabetes ..... Yes No
      1) Do you have to urinate (pass water) more than six times a day ..... Yes No
      2) Are you thirsty much of the time ..... Yes No
      3) Does your mouth frequently become dry ..... Yes No