## 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 DENTAL 1. Are you having any discomfort at this time .... No 2. Have you ever had any serious trouble associated with previous dental treatment? 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)? 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 Loose teeth..... Yes No Unpleasant taste/bad breath..... Yes Sensitive to hot..... No Yes No Burning tongue/lips Sensitive to cold Yes No No Frequent blisters, lip/mouth..... Sensitive to sweets..... Yes No No Swelling/lumps in mouth..... Yes No Sensitive to biting No Ortho treatments (braces) Food impaction..... Yes No Yes No Biting cheeks/lips ..... Yes Clenching/grinding..... No No Clicking/popping jaw..... Yes No If so, when\_\_\_\_\_ Difficulty opening or closing jaw..... Yes Shifting in bite No Change in bite Yes No 8. Do you use the following? Brush \_\_\_\_\_ No Dental floss Yes No Fluoride rinse No Other \_\_\_\_ **MEDICAL** 1. Has there been any change in your general health within the past year...... 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 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 No b. Congenital heart disease No Yes c. Cardiovascular disease (heart trouble, heart attack, heart murmur, coronary insufficiency, coronary occlusion, high/low blood pressure, arteriosclerosis, stroke, etc.) Yes No Do you have pain in chest upon exertion Yes No Are you ever short of breath after mild exercise \_\_\_\_\_ No Do your ankles swell No 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\_\_\_\_ No f. Allergy \_\_\_\_\_ No g. Sinus trouble Yes No h. Asthma or hay fever Yes No i. Hives or a skin rash Yes No Fainting spells or seizures No k. Diabetes No Do you have to urinate (pass water) more than six times a day...... 1) No Are you thirsty much of the time... Yes No Does your mouth frequently become dry \_\_\_\_\_ No

m. Arthritis or Inflammatory riteurnalism		I. Hepatitis, jaundice or liver disease	Yes	No
n. Artificial or replacement joints, prosthetic O. Digastive system—Ulcrs or stomach disorders (colitis)				
D. Digestive system—Ulcers or stomach disorders (colitis)				
q. Tubericulosis Yes No Persistant cough or cough up blood Yes No I. Persistant cough or cough up blood Yes No I. Venered lidease Yes No II. Venered III. Venered			Yes	No
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To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.