PATIENT INFORMATION AND HEALTH QUESTIONNAIRE

To help ensure your well being while undergoing treament in our office, please answer the following questions in detial. All information will be considered confidential and for our records only. Drugs, including alcohol and hormones, may influence the management of your dental treatment.

Name: 13 123 Date of Birth:

Address: Postal Code:

Home Phone: Business Phone:

Occupation: Employer:

Referred by:

Spouse's Name: Occupation: Phone #:

Contact Person: Relationship: Phone #:

Physician Name: Address: Phone #:

MEDICAL HISTORY

1. Have you recently been under the care of a physician? Yes(X) No( )

Please Specify: 12345678901234567890123456789012345678901234567890123456789012345678901234567890123456789012345678

2. Have you ever had a serious illness/ operation? Yes( ) No( )

Please Specify:

3. Are you presently taking any kind of medication, either prescribed or self-administered? Yes( ) No( )

Please Specify:

Please Specify:

4. Do you have a heart or circulatory problem of any kind? Yes( ) No( )

Please Specify:

5. Do you have any allergies? Yes( ) No( )

Please Specify:

6. Are you subject to prolonged bleeding? Yes( ) No( )

7. Have you ever has a reaction to any kind of medicine? Yes( ) No( )

Please Specify:

8. Have you ever taken penicillin? Yes( ) No( )

9. Have you ever been on steroids or cortisone? Yes( ) No( )

10. Do you presently have or have you ever had?

	Yes	No		Yes	No		Yes	No
AIDS/HIV	( )	( )	Hay Fever	( )	( )	Migraine Headaches	( )	( )
Anaemia	( )	( )	Heart Problems of any kind	( )	( )	Nervous Disorder	( )	( )
Arthritis	( )	( )	Hemorrage	( )	( )	Rheumatic Fever	( )	( )
Asthma	( )	( )	Hepatitis	( )	( )	Rheumatism	( )	( )
Blood Disorder	( )	( )	High or Low Blood Pressure	( )	( )	Scarlet Fever	( )	( )
Cancer	( )	( )	HIV Carrier	( )	( )	Stomach Ulcer	( )	( )
Chest Pain/Angina	( )	( )	Kidney Disease	( )	( )	Stroke	( )	( )
Contacts/ Cataracts	( )	( )	Liver Disease	( )	( )	Thyroid Disorder	( )	( )
Diabetes	( )	( )	Lung Disease	( )	( )	Tuberculosis	( )	( )
Epilepsy	( )	( )	Malignant Hyperthermia	( )	( )	Fainting/ Dizziness	( )	( )
Other	( )	( )						

15. Have you ever fainted? Yes( ) No( )

16. Women: Are you taking oral contraceptives? Yes( ) No( )

Are you pregnant? Yes( ) No( )

If yes, due date?

Patient's (or Parent) Signature: Date:

Patient's (or Parent) Signature: Date: