HEALTH QUESTIONNAIRE

What is the purpose of this appointment? _____

When did you last see a dentist? _____

Have you had any problems with your past dental treatment? _____

Do you have a current medical problem? _____

List any medications you are currently taking. _____

_____

Are you allergic to codeine? _____ aspirin? _____ penicillin? _____ any other drugs? _____

Do you have any other allergies? _____

Does your blood clot normally? _____

Women only: Are you pregnant? _____ Are you taking contraceptives or other hormones? _____

Place a check mark by any of the following that you have presently or have had in the past:

___ heart disease	___ heart murmur	___ rheumatic fever	___ painful, swollen joints
___ high blood pressure	___ kidney disease	___ stroke or heart attack	___ fainting
___ asthma	___ hay fever	___ diabetes	___ hives, skin rash
___ anemia	___ hepatitis (jaundice)	___ venereal disease	___ shortness of breath
___ tuberculosis	___ cancer	___ radiation treatments	___ ulcer
___ arthritis	___ major surgery	___ blow to face or jaw	___ swollen ankles
___ frequent headaches	___ serious illness	___ nervous problems	___ use of tobacco
___ blood transfusion	___ HIV positive test	___ mitral valve prolapse	___ orthodontics (braces)

Date _____ Signature _____