

Health Questionnaire



Date _____

Name _____ M _ F _ DOB _____ SocSec# _____ - _____ - _____

Address _____ Email _____

Phone: Home _____ Work _____ Cell _____

Marital Status _____ Occupation _____

Spouse's Name _____ Occupation _____

Closest Relative/Emergency Contact _____ Phone _____

Primary Dental Insurance Co _____ Secondary Dental Ins.Co _____
 Employer _____ Employer _____
 Subscriber _____ Subscriber _____
 Subscriber ID _____ Subscriber ID _____
 Date of Birth _____ Date of Birth _____

By whom were you referred to our office? _____

In the following questions, circle YES or NO, whichever applies. Your answers are part of the medical information and are considered confidential.

1. Name of primary physician _____ Phone No. _____
2. Has there been any changes in your general health in the past year?.....Yes No
3. Have you had any surgery requiring hardware/pins/screws?.....Yes No
4. Have you been hospitalized or had a serious illness within the past 5 years?.....Yes No
- Explain _____
5. Do you have or have you had any of the following diseases or problems?.....Yes No
 - a. Rheumatic fever or rheumatic heart disease.....Yes No
 - b. Congenital heart disease (murmur)Yes No
 - c. Cardiovascular disease (heart attack, high blood pressure, stroke).....Yes No
 - d. Heart Valve ReplacementYes No
 - e. Joint Replacement (hip/knee/etc...).....Yes No
 - f. Fainting spells or seizuresYes No
 - g. Diabetes.....Yes No
 - h. Hepatitis, jaundice or liver disease.....Yes No
 - i. AIDS or HIV sero positiveYes No

{PLEASE FILL OUT OTHER SIDE AND SIGN}

- j. Sinus problemsYes No
- k. Kidney problemsYes No
- l. Stomach ulcersYes No
- 6. Do you smoke?.....Yes No
- 7. Do you chew tobacco?.....Yes No
- 8. History of abnormal bleeding associated with previous extractions or surgery.....Yes No
- 9. Have you been treated for cancer?.....Yes No
 - Radiation to head/neck area?.....Yes No
- 10. Are you taking any of the following medications?.....Yes No
 - a. Antibiotics.....Yes No
 - b. Blood thinners (anticoagulants).....Yes No
 - c. High Blood pressure medications.....Yes No
 - d. Steroids.....Yes No
 - e. Aspirin.....Yes No
 - f. Insulin or diabetic medications.....Yes No
 - g. Others (list please).....Yes No
- 11. Do you take now, or took in the past medications for osteoporosis?.....Yes No
- 12. Are you allergic to any of the following? _____
 - a. Local anesthetic..... Yes No
 - b. Pencillin or other antibiotics (specify).....Yes No
 - c. Valium.....Yes No
 - d. Codeine or other narcotics.....Yes No
 - e. Aspirin.....Yes No
- 13. Women: Are you pregnant?.....Yes No

I hereby authorize and request the performance of dental services from Barats Family Dentistry, PC, including the performance of whatever procedures the judgment of the doctor may deem necessary during the performance of any dental procedures that have been mutually agreed upon. Furthermore, I will be responsible for any financial obligations incurred for dental treatment.

Signature of patient (Parent if patient is a minor) _____

Signature of Dentist _____

Medical history update:

Date _____, by _____
 Date _____, by _____
 Date _____, by _____
 Date _____, by _____

