

HEALTH QUESTIONNAIRE

Patient's First Name _____ Patient's Last Name _____

Date of Birth _____ Mo/Year of your last medical examination _____

Physician _____

Address _____ City _____ Phone () _____

How would you describe your present health (*choose one*): excellent good fair poor don't know

Does your M.D. require you to pre medicate with antibiotics prior to dental procedures? Yes No

Are you allergic to *any* medications or drugs, Latex, Iodine? Yes No

If so, please list _____

Have you ever had adverse reaction to any drugs, anesthetics, sedatives, narcotics, Aspirin, Ibuprofen (Motrin)? Yes No

Has there been any changes in your general health in the past year? Yes No

Have you had a serious illness, operation or hospitalization during the past five years? Yes No

If yes, please describe: _____

Are you taking or have you recently taken any of the following:

Prescribed medications & inhalers: _____

Over the counter, natural or herbal preparations: _____

Have you ever received I.V., or taken orally: Aredia, Zometa, Fosamax or any other bisphosphonates? Yes No

Have you ever taken Pondimin (*Fenoluramine*), Phen-Fen (*Phentermine*) or Redux (*Dexphenfluramine*) for weight reduction? Yes No

Have you ever had excessive bleeding that required special treatment? Yes No

Have you been diagnosed as having any Immunodeficiency, Systemic Lupus, ARC, or AIDS? Yes No

Is there a history of Diabetes in your family? Yes No

Are you required, due to health, to restrict your work or activity in any way? Yes No

Are you on a special or restricted diet of any kind? Yes No

Do you use any kind of tobacco? Yes No

If so, how much: per day, week, month _____

Do you use any kind of alcohol? Yes No

If so, how much: per day, week, month _____

Do you have any history or substance abuse or do you currently use recreational drugs? Yes No

For women, check all that are appropriate: I am pregnant I am nursing I am taking birth control pills

Have you experienced an unusual reaction to *any* of the following?

- | | | | | | |
|----------------------------------|-------------------------------------|-------------------------------|------------------------------------|--------------------------------|--------------------------------|
| <input type="radio"/> Penicillin | <input type="radio"/> Codeine | <input type="radio"/> Valium | <input type="radio"/> Tetracycline | <input type="radio"/> Aspirin | <input type="radio"/> Vicodin |
| <input type="radio"/> Latex | <input type="radio"/> Nitrous Oxide | <input type="radio"/> Anaprox | <input type="radio"/> Erythromycin | <input type="radio"/> Percodan | <input type="radio"/> Synalgos |
| <input type="radio"/> Tylenol | <input type="radio"/> Iodine | | | | |

Please continue on the other side ►►

HEALTH QUESTIONNAIRE

« Continued

Choose all of the following that you may have had in the past or that currently apply to you:

- | | | | |
|--|---|--|--|
| <input type="radio"/> Chest Pain Upon Exertion | <input type="radio"/> Shortness of Breath | <input type="radio"/> High Blood Pressure | <input type="radio"/> Low Blood Pressure |
| <input type="radio"/> Heart Valve Prosthesis | <input type="radio"/> Mitral Valve Prolapse | <input type="radio"/> Congenital Heart Lesion | <input type="radio"/> Rheumatic Fever |
| <input type="radio"/> Heart Murmur | <input type="radio"/> Damaged Heart Valve | <input type="radio"/> Heart Arrhythmia | <input type="radio"/> Tachycardia |
| <input type="radio"/> Heart Surgery | <input type="radio"/> Cardiac Pacemaker | <input type="radio"/> Hepatitis or Jaundice | <input type="radio"/> Received Blood Transfusion |
| <input type="radio"/> Impaired Liver Function | <input type="radio"/> Kidney Disease | <input type="radio"/> Impaired Kidney Function | <input type="radio"/> G.I. Ulcers |
| <input type="radio"/> Anorexia or Bulimia | <input type="radio"/> Irritable Bowel Syndrome | <input type="radio"/> Diabetes Type 1 | <input type="radio"/> Diabetes Type 2 |
| <input type="radio"/> Radiation Therapy | <input type="radio"/> Chemotherapy | <input type="radio"/> History of Cancer | <input type="radio"/> Sleep Apnea |
| <input type="radio"/> Asthma Bronchitis | <input type="radio"/> Emphysema | <input type="radio"/> Sinus Troubles | <input type="radio"/> Persistent Cough |
| <input type="radio"/> Tuberculosis | <input type="radio"/> Joint Replacement Surgery | <input type="radio"/> Arthritis | <input type="radio"/> Connective Tissue Disorder |
| <input type="radio"/> Osteoporosis | <input type="radio"/> Neurological Disorders | <input type="radio"/> Stroke Headaches | <input type="radio"/> Migranes |
| <input type="radio"/> Epilepsy | <input type="radio"/> Seizures | <input type="radio"/> Mental Health Problems | <input type="radio"/> Glaucoma |
| <input type="radio"/> Wear Contact Lenses | <input type="radio"/> Severely Impaired Vision | <input type="radio"/> Recurrent Infections | <input type="radio"/> Chronic Fatigue |
| <input type="radio"/> Recent Weight Loss | <input type="radio"/> Hemodialysis | <input type="radio"/> Cold Sores | |

Do you have any disease, problem or condition not listed above? Please explain: _____

DENTAL HISTORY

Frequency and type of dental care _____

Have you had previous periodontal care? Yes No

If so, when and by whom? _____

Have you ever had orthodontic treatment? Yes No

Do you have, or have you experienced any of the following?

- | | | | |
|---|--|--|--------------------------------------|
| <input type="radio"/> Bleeding Gums | <input type="radio"/> Bad Taste/Breath | <input type="radio"/> Spontaneous Tooth Movement | <input type="radio"/> Food Impaction |
| <input type="radio"/> Discomfort | <input type="radio"/> Abscesses | <input type="radio"/> Loose Teeth | <input type="radio"/> Floss Snagging |
| <input type="radio"/> Recent Tooth Loss | <input type="radio"/> Sensitivity to Biting Pressure | | |

Do you use: Gum Breath Mints Coffee Soft Drinks Tea

Is your toothbrush: Hard Medium Soft

I accept the courtesy Dr. Beagle's office offers in submitting insurance claims on my behalf. I hereby authorize the release of any information relating to said claims, and authorize as well, payment directly to Dr. Beagle's office of the group insurance benefits, otherwise payable to me. Moreover, I understand that this filing is done as a courtesy, and that I am responsible for all cost of dental treatment.

Patient Signature _____ Date _____