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Periodontics and Dental Implants

HEALTH HISTORY QUESTIONNAIRE

For your protection and to assist in our diagnosis and prescribing medication, it is necessary to know your health history. PLEASE ANSWER EACH QUESTION.

Your Name _____ Age _____

Physician _____ Address _____ Phone _____

Under Physician's Care For _____ Health Stmt. _____

Date of Last Physical Exam _____ Findings _____

	YES	NO		YES	NO
Heart Murmer-Rheumatic or Functional _____	☐	☐	Hepatitis - Type _____ When _____	☐	☐
Angina-Arm or Chest Pain on Exertion _____	☐	☐	Liver Disorder, Jaundice _____	☐	☐
Heart Trouble or Heart Attack _____	☐	☐	Venereal Disease, Herpes, AIDS _____	☐	☐
Cardiac Surgery, By-Pass, Valvular, Other_____	☐	☐	Glaucoma _____	☐	☐
Pacemaker _____	☐	☐	Tumor, Cyst, Growth, Cancer _____	☐	☐
Blood Pressure (High or Low) _____	☐	☐	Chemotherapy, Radiation Therapy _____	☐	☐
Stroke _____	☐	☐	Psychiatric Treatment - When _____	☐	☐
Prolonged Bleeding or Bruise Easily _____	☐	☐	Epilepsy, Convulsions, Seizures _____	☐	☐
Anemia _____	☐	☐	Arthritis _____	☐	☐
Ulcer, Intestinal Problems _____	☐	☐	Artificial Joint Replacement _____	☐	☐
Thyroid Condition _____	☐	☐	Tuberculosis _____	☐	☐
Diabetes - duration _____ Family member _____	☐	☐	Asthma, Emphysema _____	☐	☐
Kidney Disorder _____	☐	☐	Hayfever, Allergies _____	☐	☐
If Female, are you now:			Smoke: What _____ How many _____	☐	☐
Pregnant - Due Date _____	☐	☐	Smokeless Tobacco _____	☐	☐
Taking Birth Control Pills _____	☐	☐	Alcohol - How much _____	☐	☐
Through Menopause _____	☐	☐	Alcohol, Drug Rehab - When _____	☐	☐
Taking Hormone Medication _____	☐	☐	Chew Gum - How much _____	☐	☐

List drug allergies (including hives or skin rash)

_____

List current medications (drugs) - Include hormones or birth control pills

Medication	Purpose	Duration	Medication	Purpose	Duration

List previous dental complications

_____

List illness(es) not mentioned above _____

List hospitalizations and/or surgery in the past five years _____

_____

Signature _____ Date _____