

# MICHAEL J HUBER, DDS, MS, PC

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 Murmur-Rheumatic or Functional _____	<input type="checkbox"/>	<input type="checkbox"/>		Hepatitis - Type _____ When _____	<input type="checkbox"/>	<input type="checkbox"/>	
Angina-Arm or Chest Pain on Exertion _____	<input type="checkbox"/>	<input type="checkbox"/>		Liver Disorder, Jaundice _____	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Trouble or Heart Attack _____	<input type="checkbox"/>	<input type="checkbox"/>		Venereal Disease, Herpes, AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiac Surgery-By Pass, Valvular, Other _____	<input type="checkbox"/>	<input type="checkbox"/>		Glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>	
Pacemaker _____	<input type="checkbox"/>	<input type="checkbox"/>		Tumors, Cyst, Growth, Cancer _____	<input type="checkbox"/>	<input type="checkbox"/>	
Blood Pressure (High or Low) _____	<input type="checkbox"/>	<input type="checkbox"/>		Chemotherapy, Radiation Therapy _____	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke _____	<input type="checkbox"/>	<input type="checkbox"/>		Psychiatric Treatment - When _____	<input type="checkbox"/>	<input type="checkbox"/>	
Prolonged Bleeding or Bruise Easily _____	<input type="checkbox"/>	<input type="checkbox"/>		Epilepsy, Convulsions, Seizures _____	<input type="checkbox"/>	<input type="checkbox"/>	
Anemia _____	<input type="checkbox"/>	<input type="checkbox"/>		Arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>	
Ulcer, Intestinal Problems _____	<input type="checkbox"/>	<input type="checkbox"/>		Artificial Joint Replacement _____	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid Condition _____	<input type="checkbox"/>	<input type="checkbox"/>		Tuberculosis _____	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes - duration _____ Family member _____	<input type="checkbox"/>	<input type="checkbox"/>		Asthma, Emphysema _____	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney Disorder _____	<input type="checkbox"/>	<input type="checkbox"/>		Hayfever, Allergies _____	<input type="checkbox"/>	<input type="checkbox"/>	
If Female, are you now:				Smoke: What _____ How many _____	<input type="checkbox"/>	<input type="checkbox"/>	
Pregnant - Due Date _____	<input type="checkbox"/>	<input type="checkbox"/>		Smokeless Tobacco _____	<input type="checkbox"/>	<input type="checkbox"/>	
Taking Birth Control Pills _____	<input type="checkbox"/>	<input type="checkbox"/>		Alcohol - How much _____	<input type="checkbox"/>	<input type="checkbox"/>	
Through Menopause _____	<input type="checkbox"/>	<input type="checkbox"/>		Alcohol, Drug Rehab - When _____	<input type="checkbox"/>	<input type="checkbox"/>	
Taking Hormone Medication _____	<input type="checkbox"/>	<input type="checkbox"/>		Chew Gum - How much _____	<input type="checkbox"/>	<input type="checkbox"/>	

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 \_\_\_\_\_