HEALTH QUESTIONNAIRE

PATIENT NAME _____ **DATE** _____

Primary reason for this dental appointment _____Exam _____Emerg _____Consultation

Initial Vital Signs: BP_____ Pulse _____ Respiration _____Temperature _____

DENTAL HISTORY

Please Circle

1. yes no Do you have a specific dental problem? _____
2. yes no Would you be interested in learning about available options to improve your smile and appearance?
3. When was your last dental visit? _____
   Reason for visit? _____
4. yes no Do you brush and floss on a routine basis? Explain _____
5. yes no Have you ever had a bad or unpleasant dental experience? Describe _____

MEDICAL HISTORY

Medical Doctor's name _____ Phone # _____

Please Circle

1. yes no Are you in good health? _____
2. yes no Are you under a doctors care now? Why? _____
3. yes no Have you been hospitalized in the last two years? Why? _____
4. yes no Are you taking any medications, pills or drugs? What _____
5. yes no ARE YOU ALLERGIC TO ANY MEDICATION OR SUBSTANCE? WHAT? _____
6. yes no Are you pregnant? (Women) How many months? _____
7. yes no Do you take birth control pills? _____

WARNING! Antibiotics may alter the effectiveness of birth control pills.

Please answer all questions by checking "yes" or "no" in the appropriate box provided.

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Heart Trouble	☐	☐	Epilepsy/Seizures	☐	☐	Hepatitis B (serum)	☐	☐	Hemophilia
☐	☐	Heart Murmur	☐	☐	Cancer	☐	☐	Yellow Jaundice	☐	☐	Frequent Headaches
☐	☐	Rheumatic Fever	☐	☐	Cobalt Treatment	☐	☐	Drug Addiction	☐	☐	Allergies
☐	☐	Congenital Heart Disease	☐	☐	AIDS/HIV Positive	☐	☐	Diabetes	☐	☐	Herpes
☐	☐	Chemotherapy/Radiation	☐	☐	Glaucoma	☐	☐	Asthma	☐	☐	Venereal Disease
☐	☐	Psychiatric Care	☐	☐	Artificial Heart Valve	☐	☐	Stroke	☐	☐	Ulcers
☐	☐	Cortisone Medicine	☐	☐	Arthritis/Gout	☐	☐	Heart Pacemaker	☐	☐	Anemia
☐	☐	Heart Surgery	☐	☐	Blood Transfusion	☐	☐	Emphysema	☐	☐	Lung Disease
☐	☐	Nervousness	☐	☐	High Blood Pressure	☐	☐	Kidney Trouble	☐	☐	Tuberculosis
☐	☐	Excessive Bleeding	☐	☐	Low Blood Pressure	☐	☐	Liver Disease	☐	☐	Tumors/Growths
☐	☐	Blood Disease	☐	☐	Fainting/Dizziness	☐	☐	Hepatitis A (Infec)	☐	☐	Mitral Valve Prolapse
☐	☐	Sinus Trouble	☐	☐	Head Injuries	☐	☐	Artificial Joints/Hips	☐	☐	Jaw Pain

☐ ☐ Have You Been Advised By Your Physician To Take Antibiotic Premedication Before Your Dental Appts? If So, In What Form _____

Have you ever had any serious illness not listed above? Describe

Dr. Signature _____ (DATE)

_____

CONSENT

I hereby grant authority to Alexander H. Malick, D.M.D. and staff to perform those procedures that may be necessary or advisable for diagnosis, treatment planing, and completion of dental services for the above named patient.

SIGNED: _____ **Date** _____

Authorization must be signed by the patient, or by the responsible party in the case of minor or when the patient is physically or mentally incompetent.

Relationship to patient _____

PLEASE COMPLETE OTHER SIDE →