# Health History Questionnaire

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Date: _____

Name: (LAST, FIRST, M.I) _____ ☐ Male ☐ Female

Date of Birth: _____ Height: _____ Weight: _____

## GENERAL HEALTH

Date of Last Doctor Visit: _____ Reason for Visit: _____

Name of Primary Doctor: _____ Phone: _____

Date of Last Hospital Admission: _____ Reason for Admission: _____

Name of Specialist: _____ Type: _____ Phone: _____

What are your dental concerns? _____

**Please mark Yes or No for EVERY Question:**

| Yes | No | |
|---|---|---|
| ☐ | ☐ | High Blood Pressure? *Controlled with medication Y/N?* |
| ☐ | ☐ | Chest Pain or angina? *Last Episode:* _____ |
| ☐ | ☐ | Heart attack, heart disease? *Date:* _____ |
| ☐ | ☐ | Cardiac surgery? *Date:* _____ |
| ☐ | ☐ | Shortness of breath? |
| ☐ | ☐ | Heart murmur, mitral valve prolapse (MVP)? *Valve Replacement Y/N?* |
| ☐ | ☐ | Congenital heart defect, infective endocarditis, rheumatic fever? |
| ☐ | ☐ | Cardiac pacemaker/defibrillator? *Surgery Date:* _____ |
| ☐ | ☐ | Stroke, Deep Vein Thrombosis, Cerebrovascular Accident, Transient Ischemic Attack? *Date:* _____ |
| ☐ | ☐ | Sinusitis, seasonal allergy? |
| ☐ | ☐ | Asthma? *Hospitalized Y/N? Last ER visit:* _____ |
| ☐ | ☐ | Emphysema, Chronic Obstructive Pulmonary Disease? |
| ☐ | ☐ | Tuberculosis: *present or past*? |
| ☐ | ☐ | HIV positive, ARC, AIDS? |
| ☐ | ☐ | COVID positive? *Date:* _____ |
| ☐ | ☐ | Organ transplant? *Date:* _____ *Type:* _____ |

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Do you have obstructive sleep apnea? |
| ☐ | ☐ | Do you use CPAP? Or BiPAP? |
| ☐ | ☐ | On Oxygen? *L/min:* _____ |
| ☐ | ☐ | Liver disease, Hepatitis *(A, B or C)*? |
| ☐ | ☐ | Tumor/growth? *Where*? _____ |
| ☐ | ☐ | Cancer? *Type:* _____ |
| ☐ | ☐ | Chemotherapy or radiation therapy? *Last date:* _____ |
| ☐ | ☐ | Seizures, epilepsy, fainting, dizziness? |
| ☐ | ☐ | Arthritis (Osteoarthritis or Rheumatoid arthritis)? |
| ☐ | ☐ | Osteoporosis/osteopenia? |
| ☐ | ☐ | Artificial joints/replacement(s)? *Type:* _____ *Surgery Date:* _____ |
| ☐ | ☐ | Jaw joint problems (TMJ)? |
| ☐ | ☐ | Headaches, Migraines? |
| ☐ | ☐ | Diabetes? *Insulin dependent Y/N? Last blood sugar:* _____ */HgbA1C:* _____ |
| ☐ | ☐ | Thyroid problems (Hypo or Hyper)? |
| ☐ | ☐ | Anemia? |
| ☐ | ☐ | Bruise easily, abnormal or prolonged bleeding: |
| ☐ | ☐ | Sickle cell trait/disease? |
| ☐ | ☐ | Kidney/urinary tract problems? |
| ☐ | ☐ | Are you pregnant? *Trimester:* _____ |
| ☐ | ☐ | Are you nursing? |
| ☐ | ☐ | Short of breath walking up stairs? |

# Health History Questionnaire

## MEDICATIONS

List your prescribed drugs and over-the-counter drugs, such as vitamins, herbal supplements, such as ginger, garlic and ginseng, and inhalers. Include current and past medications taken for bone disease, cancer, or osteoporosis (ie: Fosamax, Actonel, Boniva, Zometa, Aredia)

| Name of Medication | Reason Taken | Frequency Taken | Strength |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

(Attach additional documentation if needed)

## ALLERGIES

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Local anesthetics (lidocaine) |
| ☐ | ☐ | General anesthetics |
| ☐ | ☐ | Aspirin |
| ☐ | ☐ | Soy, nuts, eggs |
| ☐ | ☐ | Codeine/narcotics |
| ☐ | ☐ | Penicillin/Sulfa Drugs |
| ☐ | ☐ | Latex |
| ☐ | ☐ | Other: _____ |

## MENTAL HEALTH HISTORY

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Obsessive Compulsive Disorder (OCD) |
| ☐ | ☐ | Dementia |
| ☐ | ☐ | Autism |
| ☐ | ☐ | Cerebral Palsy (CP) |
| ☐ | ☐ | Schizophrenia |
| ☐ | ☐ | Depression |
| ☐ | ☐ | Bipolar disorder |
| ☐ | ☐ | Personality disorder |
| ☐ | ☐ | Anxiety |

Therapist Name: _____

Phone: _____

## SOCIAL HABITS/HISTORY

All questions contained in this questionnaire will be kept strictly confidential.

| Yes | No | | If YES please specify: |
|---|---|---|---|
| ☐ | ☐ | Do you smoke? Use smokeless tobacco? | Packs per day: _____ Years: _____ |
| ☐ | ☐ | Do you use recreational drugs? | Number of Years: _____<br>Type: ☐ Cocaine ☐ Meth ☐ Heroin ☐ Marijuana |
| ☐ | ☐ | Do you use alcohol? | Drinks per week: _____<br>Type: ☐ Wine ☐ Beer ☐ Liquor |
| ☐ | ☐ | Are you in Treatment/Recovery? | Treatment for: _____ Date sober: _____ |

## SURGICAL HISTORY

List any previous surgeries or procedures

| Surgery | Date |
|---|---|
| | |
| | |
| | |
| | |

**Adverse Reactions to above surgeries:**

| Yes | No | | If yes please specify: |
|---|---|---|---|
| ☐ | ☐ | Nausea and Vomiting? | |
| ☐ | ☐ | Prolonged Bleeding? | |
| ☐ | ☐ | Malignant Hyperthermia? | |
| ☐ | ☐ | Blood Transfusions? | |

Have you gone to the hospital or emergency room or had a serious illness in the last three years? ☐ Yes ☐ No

If YES, explain:

List any other conditions not listed above:

*I hereby certify that the above information regarding the medical history is complete, true, and correct and may be relied upon for all purposes by the Doctor, their assistants, colleagues, staff employees, and any other persons treating or assisting the treatment of the patient.*

SIGNATURE, RELATIONSHIP (IF OTHER THAN PATIENT) DATE