HEALTH QUESTIONNAIRE

PATIENT NAME _____ **DATE** _____

Primary reason for this dental appointment: Exam _____ Emergency _____ Consultation _____
Initial Vital Signs: BP _____/_____ Pulse _____ Respiration _____ Temperature _____ General Appearance:_____
Emergency Contact:_____ Phone#:_____

DENTAL HISTORY

Please Circle

Yes No Do you have a specific problem? _____
Yes No Do you have dental exams on a routine basis? Last visit _____ Purpose_____ Last FM X-rays_____
Yes No Dentist's Name, Address, and Phone # _____
Yes No Would you describe your present dental health as good? Comments _____
_____
Yes No Do you think you have active decay or gum disease? _____
Yes No Do your gums bleed? Discuss _____
Yes No Do you brush and floss on a daily basis? How often? _____
Yes No Have you ever had a bad or unpleasant dental experience? Describe _____
_____
Yes No Following dental treatment or injuries, have you had bleeding problems? _____
Yes No Do you ever grind your teeth? Explain _____
Yes No Do you ever have clicking, popping, or discomfort in the jaw joints (TMJ)? Explain _____
_____

MEDICAL HISTORY

Medical Doctor's name _____ Phone # _____

Please Circle

Yes No Are you in good health? _____
Yes No Are you under a doctor's care now? Why? _____
Yes No Have you been hospitalized in the last two years? Why? _____
Yes No Are you taking any medications, pills, or drugs? What? _____
_____
Yes No ARE YOU ALLERGIC TO ANY MEDICATION, ANESTHETIC OR SUBSTANCE? WHAT? _____
_____
Yes No Are you pregnant? (Women) How many months? _____
Yes No Do you take birth control pills? _____
WARNING! Antibiotics may alter the effectiveness of birth control pills.

Please answer all questions by circling "yes" or "no".

Yes No Heart Disease	Yes No Epilepsy / Seizures	Yes No Hepatitis B (serum)	Yes No Hemophilia
Yes No Heart murmur	Yes No Cancer	Yes No Yellow Jaundice	Yes No Heart Attack
Yes No Rheumatic Fever	Yes No Thyroid Disease	Yes No Alcohol / Drug Addiction	Yes No Allergies (incl. Latex)
Yes No Diabetic	Yes No AIDS / HIV Positive	Yes No Congenital Heart Disease	Yes No Herpes
Yes No Asthma	Yes No Venereal Disease	Yes No Chemotherapy / Radiation	Yes No Glaucoma
Yes No Psychiatric Care	Yes No Stroke	Yes No Artificial Heart Valve	Yes No Ulcers
Yes No Anemia	Yes No Arthritis / Gout	Yes No Cortisone Medicine	Yes No Heart Pacemaker
Yes No Heart Surgery	Yes No Blood Transfusion	Yes No Lung Disease	Yes No Emphysema
Yes No Nervousness	Yes No High Blood Pressure	Yes No Kidney Trouble	Yes No Tuberculosis
Yes No Liver Disease	Yes No Excessive Bleeding	Yes No Low Blood Pressure	Yes No Tumor / Growth
Yes No Blood Disease	Yes No Fainting / Dizziness	Yes No Hepatitis A (infectious)	Yes No Smoke
Yes No Sinus Trouble	Yes No Mitral Valve Prolapse	Yes No Artificial Joints / Hips	Yes No Head Injuries

Yes No Past or Present Use of Diet Meds (such as Phen- Fen)

Have you been advised by your physician to take antibiotic premedication before your dental appointments? Yes No If so, in what forms?_____

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

CONSENT

To the best of my knowledge, all of the preceding answers are correct. If I ever have any change in my health history I will inform the staff at the next appointment without fail. I hereby grant authority to Vinh T. Pham, D.D.S. and staff to perform those procedures that may be necessary or advisable for diagnosis, treatment planning, and completion of dental services for the above named patient.

SIGNED: _____ **DATE** _____

MEDICAL SUMMARY: _____
_____Reviewed By:_____ Date:_____

MEDICAL HISTORY