Health History Questionnaire

DENTALCARE
ROLAND L. ELAZEGUI, DMD, INC.

Patient Name *First* _____ *Last* _____

Physician Name _____ Physician's Phone (____) ____ - ____

Physician Adddress *Street* _____ *City* _____ *Zip Code* _____

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care.

Please answer each question on both sides of the form. Check **Yes** or **No** where applicable.

1 Are you in good health? ☐ Yes ☐ No

2 Date of last physical examination? _____

3 Are you now under the care of a physician? ☐ Yes ☐ No

If so, what is the condition that is being treated? _____

4 Have you ever had any serious illness or operation? ☐ Yes ☐ No

If so, what illness or operation? _____

5 Have you ever been hospitalized? ☐ Yes ☐ No

If so, what was the problem? _____

6 Are you taking any medication? ☐ Yes ☐ No

If so, what medication? _____

Are you taking ***Bisphosphonates*** *(Fosamax, Boniva, Actonel, Reclast, etc.)* ? ☐ Yes ☐ No

7 Are you taking any recreational drugs? ☐ Yes ☐ No

If so, what drugs? _____

8 Have you ever been pre-medicated with antibiotics for your dental treatment? ☐ Yes ☐ No

9 Are you sensitive or allergic to any drugs or materials? ☐ Yes ☐ No

☐ Penicillin ☐ Tetracycline ☐ Sulfa Drugs ☐ Aspirin ☐ Codeine ☐ Latex ☐ Metal ☐ Other

If Other, what drugs? _____

10 Do you have or have you had any of the following? Please check **Yes** or **No** where applicable.

Aquired Immune Deficiency Syndrome	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Angina Pectoris	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No
Chemotherapy (Cancer,Leukemia)	☐ Yes	☐ No
Chicken Px	☐ Yes	☐ No
Cold Sores	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Scarlet Fever	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Sinus Trouble	☐ Yes	☐ No
Sleep Apnea	☐ Yes	☐ No

Drug Addiction	☐ Yes	☐ No
Epilepsy or Seizures	☐ Yes	☐ No
Excessive Bleeding	☐ Yes	☐ No
Fainting Spells	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Hay Fever	☐ Yes	☐ No
Head Injuries	☐ Yes	☐ No
Heart Ailments or Attack	☐ Yes	☐ No
Heart Failure	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No
Hepatitis or Jaundice	☐ Yes	☐ No
Snoring	☐ Yes	☐ No
Stomach Ulcers	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Tonsilitis	☐ Yes	☐ No

Herpes	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
HIV Related Complex	☐ Yes	☐ No
Implant _____	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No
Nervous / Emotional Problems	☐ Yes	☐ No
Osteoporosis	☐ Yes	☐ No
Psychiatric Treatment	☐ Yes	☐ No
Radiation Treatment	☐ Yes	☐ No
Respiratory Disease	☐ Yes	☐ No
Rheumatism	☐ Yes	☐ No
Ulcer	☐ Yes	☐ No
Veneral Disease (Syphilis, Gonorrhea)	☐ Yes	☐ No
X-Ray or Cobalt Treatment	☐ Yes	☐ No

Health History Questionnaire (Continued)

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11 Do you wear a cardiac pacemaker, or have you had heart surgery? ☐ Yes ☐ No

12 Do you have any disease, condition, or problem that you think we should know about? ☐ Yes ☐ No

If so, what? _____

13 Do you smoke? ☐ Yes ☐ No

If yes, how much? ☐ Cigarettes ☐ Cigars ☐ Packs _____ per day

14 (Women) Are you pregnant? If so, how many months? _____ ☐ Yes ☐ No

15 (Women) Do you have any problems associated with your menstrual period? ☐ Yes ☐ No

16 (Women) Do you take any birth control medication? ☐ Yes ☐ No

Health History

To the best of my knowledge, all of the preceding answers regarding my health history are true and correct. If lever have any change in my health or if my medications change, I will without fail, inform the doctor at my next appointment. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature _____ Date _____

Relationship to patient (if patient is a minor) _____

For eDental Care Staff Only

Reviewed by _____ Date _____

Additional Notes

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