JEFFREY C. WEST, DMD - General Dentistry

Health History Questionnaire

Name _____ **Date of birth** _____ **Today's Date** _____

Instructions: *Please read and review all questions. Answer all questions by circling yes, no, or unsure. All questions should be answered truthfully. Incorrect or omitted information may be dangerous to your health. Please explain any yes or unsure answers on the line provided. Please list medication names and dosages.*

Name and phone number of physician(s): _____

Do you take any type of antibiotic?	Yes	No	Unsure	_____
Do you take any type of heart medication?	Yes	No	Unsure	_____
Do you take any type of blood thinner?	Yes	No	Unsure	_____
Do you take any antidepressants?	Yes	No	Unsure	_____
Do you take birth control pills?	Yes	No	Unsure	_____
Do you take hormones, cortisone or steroids?	Yes	No	Unsure	_____
Do you take any other medications?	Yes	No	Unsure	_____
Are you allergic to Novocaine?	Yes	No	Unsure	_____
Are you allergic to Penicillin or any antibiotics?	Yes	No	Unsure	_____
Are you allergic to Latex?	Yes	No	Unsure	_____
Are you allergic to any narcotics?	Yes	No	Unsure	_____
Do you have any other allergies?	Yes	No	Unsure	_____
Have you ever had Rheumatic heart Disease?	Yes	No	Unsure	_____
Have you ever had a congenital heart disease?	Yes	No	Unsure	_____
Have you ever had a heart murmur?	Yes	No	Unsure	_____
Have you ever had a heart attack?	Yes	No	Unsure	_____
Have you ever had angina?	Yes	No	Unsure	_____
Have you ever had heart surgery?	Yes	No	Unsure	_____
Do you have a pacemaker?	Yes	No	Unsure	_____
Do you have a prosthetic heart valve?	Yes	No	Unsure	_____
Have you ever had excessive bleeding?	Yes	No	Unsure	_____
Have you ever had low or high blood pressure?	Yes	No	Unsure	_____
Have you ever had Asthma?	Yes	No	Unsure	_____
Have you ever had Tuberculosis?	Yes	No	Unsure	_____
Have you ever undergone radiation treatment?	Yes	No	Unsure	_____
Have you ever had chemotherapy?	Yes	No	Unsure	_____
Have you ever had cancer?	Yes	No	Unsure	_____
Do you have Diabetes?	Yes	No	Unsure	_____
Have you ever had a joint surgery?	Yes	No	Unsure	_____
Do you have any internal plates or rods?	Yes	No	Unsure	_____
Have you ever had Hepatitis?	Yes	No	Unsure	_____
Have you ever had liver disease?	Yes	No	Unsure	_____
Have you ever had any kidney problems?	Yes	No	Unsure	_____
Have you ever had kidney dialysis?	Yes	No	Unsure	_____
Have you ever had a psychiatric disorder?	Yes	No	Unsure	_____
Have you ever been treated by a psychiatrist or counselor?	Yes	No	Unsure	_____
Have you ever had depression or fatigue syndrome?	Yes	No	Unsure	_____
Have you ever suffered a stroke?	Yes	No	Unsure	_____
Have you been diagnosed with AIDS/HIV?	Yes	No	Unsure	_____
Have you ever had Syphilis, Herpes or Gonorrhea?	Yes	No	Unsure	_____
Have you ever had a serious head or neck injury?	Yes	No	Unsure	_____
Have you ever had a major operation?	Yes	No	Unsure	_____
Do you use smokeless tobacco products?	Yes	No	Unsure	_____
Have you ever used recreational drugs?	Yes	No	Unsure	_____
How much alcohol do you drink a week?				_____ a week
How many packs of cigarettes do you smoke?				_____ a day
Do you have any medical condition we should be aware of?	Yes	No	Unsure	_____
(*For women*) Are you pregnant?	Yes	No	Unsure	_____
(*For women*) Are you breastfeeding?	Yes	No	Unsure	_____

Dental History

What dental problem brought you in today?				_____
Do you have any dental concerns or complaints?	Yes	No	Unsure	_____
Are you worried about receiving dental care?	Yes	No	Unsure	_____
Any complications following dental treatment?	Yes	No	Unsure	_____
Are you happy with the appearance of your teeth?	Yes	No	Unsure	_____
Have you ever had an injury to your teeth, jaw or face?	Yes	No	Unsure	_____
How often do you brush your teeth?				_____ a day
How often do you floss?				_____ a week
Is there fluoride in your drinking water?	Yes	No	Unsure	_____
Do you grind your teeth?	Yes	No	Unsure	_____
Do any of your teeth hurt?	Yes	No	Unsure	_____
Are your teeth sensitive to hot or cold?	Yes	No	Unsure	_____
Are any of your teeth becoming loose?	Yes	No	Unsure	_____
Any growths or sores in your mouth?	Yes	No	Unsure	_____
Have your teeth shifted?	Yes	No	Unsure	_____
Do your gums bleed?	Yes	No	Unsure	_____
Do you have any previous dental x-rays?	Yes	No	Unsure	_____

Date of last dental visit: _____

Reason for last dental visit: _____

I understand the need for these questions to be answered truthfully and to the best of my knowledge. The answers I have given are accurate. I also understand it is very important to report any change in my medical or dental status to the dentist at the earliest possible time and I agree to do so. I give my permission to the dentist to obtain from my personal physician any additional information regarding my medical history needed to provide me the best dental care treatment possible.

Person completing this form (signature) _____ Date _____

If other than patient, relationship _____

(*Office Use Only*) Reviewed by _____ Reviewed by _____ Reviewed by _____

Health History Update

Initials _____ Date _____ Comments _____

Initials _____ Date _____ Comments _____

Initials _____ Date _____ Comments _____