



HEALTH QUESTIONNAIRE

Please mark all that apply

1. CARDIOVASCULAR DISEASE

- Low Blood Pressure
- High Blood Pressure
- Arteriosclerosis
- Heart Attack
- Heart Bypass Surgery
- Prosthetic Heart Valves
- Congenital Heart Malformations
- Hypertrophic Cardiomyopathy
- Mitral Valve Prolapse
- Heart Murmur
- Rheumatic Fever
- Bacterial Endocarditis
- Heart Stents or Shunts
- Osteoporosis
- Other _____

2. OTHER

- Diabetes, taking insulin?
- Insulin name:
- Blood transfusion since 1980?
- Hepatitis: A B C
- Jaundice, liver disease
- Stomach Ulcers
- Kidney Problems
- Arthritis or Rheumatism
- Tuberculosis
- Venereal Disease or AIDS virus

4. ARE YOU CURRENTLY TAKING ANY MEDICATIONS?

- Abnormal Bleeding
- Anemia
- Cancer: Radiation / Chemotherapy
- Have you had any joint replacements?
- Are you pregnant? How many months?
- Sinus trouble
- Hay Fever
- Asthma
- Cocaine use
- Stroke
- Angina / Chest Pain
- Irregular Heartbeat
- Pacemaker / Implanted Defibrillator
- Autoimmune Disease / Lupus
- Thyroid Disease
- Organ Transplant
- Epilepsy / Seizure
- Psychiatric Treatment
- Emphysema / Bronchitis
- Other _____

3. ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

- Penicillin / Antibiotics
- Sulfa Drugs
- Codeine
- Iodine
- Aspirin
- Local Anesthetic

MEDICATION LIST:



- Sulfa Drugs
- High Blood Pressure
- Tranquilizers
- Aspirin
- Antihistamines
- Cortisone
- Digitalis
- Drugs for Heart Disease
- Antibiotics
- Names of Antibiotic: _____
- Date Started: _____
- Vitamins and/or Herbals
- Appetite Suppressants

List any other medications you are taking currently:

5. ARE YOU TAKING ANY OF THE FOLLOWING MEDICATIONS?

Fosamax, Actonel, Boniva, Didronel, Skelid, Aredia, Bonefos, Zometa?

6. HAVE YOU HAD ANY PROBLEMS ASSOCIATED WITH PREVIOUS DENTAL TREATMENTS?

7. HAVE YOU HAD ANY SERIOUS ILLNESSES OR OPERATIONS IN THE PAST?

Patient Name

Patient/Legal Guardian Signature

Date