

Health Questionnaire

Please complete all of the following questions. PLEASE PRINT

Name _____ Birthdate _____
Height _____ Weight _____

PLEASE ✓ NEXT TO ALL THAT PERTAIN TO YOUR HEALTH NOW OR IN THE PAST

HEPTO-RETNAL

- Hepatitis or yellow Jaundice
- Liver or gall bladder disease
- Kidney disease or kidney stones
- Bladder or urinary infections

PULMONARY

- Tobacco use
- Any respiratory problem
- Asthma
- Had a cold in the last month
- Have a morning cough
- Tuberculosis

NEUROLOGIC

- Problems with nervous system
- Ever lost consciousness
- Convulsions or seizures
- Ever lost your vision
- Nervous disorder
- Recurring headaches
- Back or neck aches
- Fibromyalgia
- Episodes of panic
- Local anesthetic reaction
- Reaction to sedation medication

DENTAL

- TMJD
- Jaw pop, click or stick
- Gag easily
- Neck support in the dental chair

CARDIOVASCULAR

- Chest pain
- Heart attack or stroke
- Replacement valve or implant
- Rheumatic fever
- High or Low Blood pressure
- Blood pressure medication?
- Heart murmur
- Heart medication
- Shortness of breath
- Pre-meds for dental treatments

GENERAL

- Bruise easily or Prolonged bleeding
- Ulcer
- Diabetes, Type I _____ Type II _____
- Alcoholism, drug, or narcotics dependency
- Immune system condition/HIV
- Glaucoma
- Sinusitis/Sinus problem/Allergies
- Artificial joints, implants or pins
- Are you pregnant/Nursing
- Susceptible to yeast infections
- Claustrophobic

PLEASE LIST ALL MEDICATION (prescription or non-prescription) AND THE REASON FOR TAKING THEM.

DO YOU TAKE DAILY ASPIRIN OR OTHER BLOOD THINNING MEDICATION? _____

ANY PREVIOUS SURGERIES:

ALLERGIES TO MEDICATIONS:

IS THERE ANY OTHER INFORMATION WE SHOULD KNOW ABOUT YOUR HEALTH?

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNED _____ DATE _____