



# HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential.

Name:

DOB:

What concerns do you have about your teeth or smile?

Immediate:

Long Term:

Are you apprehensive about dental treatment?

Y  N

When was your last dental visit?

\_\_\_\_/\_\_\_\_/\_\_\_\_

Do you have a sore or hoarse throat?

Y  N

Do you have any sores or lumps in your mouth?

Y  N

## MEDICAL HISTORY

Are you in good health?

Y  N

Has your health changed in the past year

Y  N

Are you currently being treated by a physician for any condition?

Y  N

When was your last physical examination? \_\_\_\_/\_\_\_\_/\_\_\_\_

Have you had a serious illness or been hospitalized in the past 5 years?  Y  N

## Medications including prescriptions, over the counter medications and natural/herbal supplements:

Name:	For:	Dose:

## MEDICAL ISSUES

Check if you have, or have had, any of the following diseases, problems or conditions:

HAVE HAD	HAVE HAD	HAVE HAD
<input type="checkbox"/> <input type="checkbox"/>	Infective Endocarditis	<input type="checkbox"/> <input type="checkbox"/> Sinus problems
<input type="checkbox"/> <input type="checkbox"/>	Damaged or artificial heart valves	<input type="checkbox"/> <input type="checkbox"/> Emphysema, Bronchitis or other respiratory problems
<input type="checkbox"/> <input type="checkbox"/>	Congenital Heart Defects	<input type="checkbox"/> <input type="checkbox"/> Seasonal, pet or similar allergies
<input type="checkbox"/> <input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> Asthma
<input type="checkbox"/> <input type="checkbox"/>	Heart Attack	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis
<input type="checkbox"/> <input type="checkbox"/>	Cardiovascular Disease (Arteriosclerosis)	<input type="checkbox"/> <input type="checkbox"/> Stomach ulcers or colitis
<input type="checkbox"/> <input type="checkbox"/>	Chest pain on exertion	<input type="checkbox"/> <input type="checkbox"/> Kidney trouble
<input type="checkbox"/> <input type="checkbox"/>	Shortness of breath from mild exertion or when laying down	<input type="checkbox"/> <input type="checkbox"/> Thyroid problems
<input type="checkbox"/> <input type="checkbox"/>	Swollen ankles	<input type="checkbox"/> <input type="checkbox"/> Diabetes
<input type="checkbox"/> <input type="checkbox"/>	Cardiac pacemaker or defibrillator	<input type="checkbox"/> <input type="checkbox"/> Relative with diabetes
<input type="checkbox"/> <input type="checkbox"/>	Cancer	Please specify:
<input type="checkbox"/> <input type="checkbox"/>	Treatment for a tumor or growth?	Treatment used:
<input type="checkbox"/> <input type="checkbox"/>	Mental health disorders	Please specify:

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**NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

### ALLERGIES

Are you allergic to latex?	<input type="checkbox"/> Y <input type="checkbox"/> N
Are you allergic to any medicine or drug?	<input type="checkbox"/> Y <input type="checkbox"/> N

\*ex- penicillin, local anesthetics, sulfas, aspirin, codeine

### WOMEN ONLY

Are you pregnant or nursing?	<input type="checkbox"/> Y <input type="checkbox"/> N
Are you taking birth control pills?	<input type="checkbox"/> Y <input type="checkbox"/> N

### BISPHOSPHONATES

New information has shown that certain bone strengthening medications may affect the mouth.  
It is very important that we know if you are **TAKING OR HAVE TAKEN** any of the following medications:

Alendronate (Fosamax)	<input type="checkbox"/> Y <input type="checkbox"/> N	Residronate (Actonel)	<input type="checkbox"/> Y <input type="checkbox"/> N
Atelvia (risedronate sodium)	<input type="checkbox"/> Y <input type="checkbox"/> N	Ibandronate (Boniva)	<input type="checkbox"/> Y <input type="checkbox"/> N
Reclast (zoledronic acid injection)	<input type="checkbox"/> Y <input type="checkbox"/> N		

If yes to the above question, how long ago did you take the medication? \_\_\_\_\_ How long did you take the medication? \_\_\_\_\_

Some other bone strengthening medications are given intravenously in the hospital for certain types of cancer (metastatic deposits from multiple myeloma or breast, prostate, renal or lung cancers.) Have you ever been given either of the following medications intravenously?

Pamidronate (Aredia)	<input type="checkbox"/> Y <input type="checkbox"/> N	Zoledronate (Zometa)	<input type="checkbox"/> Y <input type="checkbox"/> N
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### TMJ

Have you ever been diagnosed with a problem with either jaw joint?	<input type="checkbox"/> Y <input type="checkbox"/> N
Does your jaw click, pop or make noise when you open or close? If not now, in the past?	<input type="checkbox"/> Y <input type="checkbox"/> N
Do you have pain or tenderness in your jaw when you open, close or chew?	<input type="checkbox"/> Y <input type="checkbox"/> N
Has your jaw ever locked open or closed?	<input type="checkbox"/> Y <input type="checkbox"/> N
Do you have frequent headaches? If so, how often and where?	<input type="checkbox"/> Y <input type="checkbox"/> N
Do you clench or grind your teeth, or been told that you do?	<input type="checkbox"/> Y <input type="checkbox"/> N
Do you have a history of trauma to your chin or jaw?	<input type="checkbox"/> Y <input type="checkbox"/> N
Do you or have you ever worn a night guard?	<input type="checkbox"/> Y <input type="checkbox"/> N

### SLEEP APNEA (STOP BANG)

Do you <b>s</b> nore loudly (louder than talking/ can you be heard through closed doors?)	<input type="checkbox"/> Y <input type="checkbox"/> N
Do you often feel <b>t</b> ired, fatigues or sleepy during daytime?	<input type="checkbox"/> Y <input type="checkbox"/> N
Has anyone <b>o</b> bserved your breathing stop during sleep?	<input type="checkbox"/> Y <input type="checkbox"/> N
Do you have or are you being treated for high blood <b>p</b> ressure?	<input type="checkbox"/> Y <input type="checkbox"/> N

**B**MI -Please list your weight \_\_\_\_\_ lbs Please list your height \_\_\_\_\_' \_\_\_\_\_"

\***provider** calculation formula – lbs/inches<sup>2</sup> x 703 must be ≥ 35  Y  N

Are you over 50 years of <b>a</b> ge?	<input type="checkbox"/> Y <input type="checkbox"/> N
Is your <b>n</b> eck greater than 17 inches for a male or 16 inches for a female?	<input type="checkbox"/> Y <input type="checkbox"/> N

Are you male? (**g**ender)  Y  N

Yes for 0-2 questions is low risk

Yes for 3-4 questions is intermediate risk

Yes for 5-8 questions is high risk