Smile
206-542-7000
747 N 185th Street #202
Shoreline WA 98133

B.P. _____

Pulse: _____

HEALTH QUESTIONNAIRE

Name _____ Date _____

Birthdate _____ Height _____ Weight _____ Sex _____

Medical Doctor's Name _____ Medical Doctor's Phone (_____) _____

Medical Doctor's Address _____

Previous Dentist's Name _____ Phone (_____) _____ Last seen _____

Why are you now seeking dental treatment? _____

Please circle your response.

1. Have you ever been told by a physician that you have a **heart murmur?** .....Yes .....No

2. Has your physician ever recommended that you be **pre-medicated** with antibiotics before dental treatment? .....Yes .....No

3. Do you now have or have you ever had any **heart trouble?** (i.e. Rheumatic fever, angina, etc.) .....Yes .....No

4. Do you have **high blood pressure?** .....Yes .....No

5. Do you have any **artificial prostheses** in your body? .....Yes .....No
(i.e. metal screws, plates, pins, etc. Please specify) _____

6. Have you ever experienced any unusual **reactions or allergies** to any of the following drugs:

A. Penicillin .....Yes .....No
B. Other antibiotics .....Yes .....No
C. Codeine .....Yes .....No
D. Aspirin .....Yes .....No
E. Sulfa drugs .....Yes .....No
F. Other medicines (please specify) .....Yes .....No
G. _____
H. _____

Please list all current medications and herbal or supplements you are taking:

	Name of Medication/Supplement	Dosage/mg	Frequency	Condition
1.				
2.				
3.				
4.				
5.				

7. Do you have any **allergies** (to foods, dust, latex, metal, etc.) .....Yes .....No

8. Do you now or have you ever used tobacco products? .....Yes .....No

9. Have you been examined by a physician within the last year? .....Yes .....No

10. Has there been any change in your general health in the past year? .....Yes .....No

11. Have you lost or gained weight in recent months? .....Yes .....No

12. Have you ever been seriously ill? .....Yes .....No

Please continue on the reverse side ➔

13. Have you ever been hospitalized? If yes, please explain. _____Yes .....No

_____

_____

14. Have you ever had a blood transfusion?.....Yes.....No
15. Have you ever been treated for a growth or a tumor in any part of your body? .....Yes.....No
16. Are you frequently ill? .....Yes.....No
17. Do you often feel exhausted or fatigued?.....Yes.....No
18. Have you ever had a painful or swollen joint? .....Yes.....No
19. Do you bleed for a long time when you cut yourself?.....Yes.....No
20. Have you ever had any of the following diseases or conditions:

A. Jaundice (yellow skin & eyes).....Yes.....No
B. Hepatitis.....Yes.....No
C. HIV (AIDS) .....Yes.....No
D. Tuberculosis.....Yes.....No
E. Venereal disease .....Yes.....No
F. Heart attack .....Yes.....No
G. Stroke.....Yes.....No
H. Ulcers.....Yes.....No
I. Epilepsy .....Yes.....No
J. Diabetes (sugar disease) .....Yes.....No
K. Measles.....Yes.....No
L. Chicken pox .....Yes.....No
M. Mumps.....Yes.....No
N. Polio .....Yes.....No
O. Rheumatic fever.....Yes.....No
P. Scarlet fever .....Yes.....No
Q. Herpes.....Yes.....No
R. Glaucoma.....Yes.....No

21. Do you have any blood disorder such as anemia (thin blood)?.....Yes.....No
22. Do you have any chest pain on exertion? .....Yes.....No
23. Are you ever short of breath on mild exertion?.....Yes.....No
24. Do your ankles ever swell?.....Yes.....No
25. Do you have a persistent cough? .....Yes.....No
26. Do you have asthma?.....Yes.....No
27. Do you ever have hay fever?.....Yes.....No
28. Do you ever have hives or skin rash?.....Yes.....No
29. Have you ever experienced an unusual reaction to a dental anesthetic (Novocaine)?.....Yes.....No
30. Do you usually have to urinate frequently?.....Yes.....No
31. Are you thirsty much of the time?.....Yes.....No
32. Has a doctor ever said you had kidney or bladder disease or infection?.....Yes.....No
33. Has a doctor ever said you had liver disease?.....Yes.....No
34. Do you have any numbness or tingling in any part of your body?.....Yes.....No
35. Has any part of your body ever been paralyzed?.....Yes.....No
36. Do you ever have fits or convulsions?.....Yes.....No
37. Do you have a tendency to faint?.....Yes.....No
38. Do you have frequent severe headaches?.....Yes.....No
39. Women — Are you presently pregnant? .....Yes.....No

This is to certify that the information above is a true representation of my health status as of this date.

Patient Signature _____ **Date**_____

Thank you for taking the time to fill out our health questionaire.