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Practice Limited to Periodontics • Implants • Laser Surgery

HEALTH QUESTIONNAIRE

ANSWERS TO THE FOLLOWING QUESTIONS ARE FOR OUR RECORDS ONLY. NATURALLY THEY WILL BE CONSIDERED CONFIDENTIAL AND WILL BECOME PART OF YOUR PERMANENT DENTAL RECORD

NAME: _____ SOCIAL SECURITY NUMBER: _____

ADDRESS: _____ DATE OF BIRTH: _____

_____ TELEPHONE (HOME): _____

DENTAL INSURANCE COMPANY: _____ (WORK): _____

POLICY NUMBER: _____ BUSINESS: _____

2ND DENTAL INSURANCE: _____ BUSINESS ADDRESS: _____

IN CASE OF EMERGENCY: _____ _____

REFERRING DENTIST: _____ DENTIST'S PHONE: _____

MEDICAL DOCTOR: _____ M.D.'S PHONE: _____

WHAT IS YOUR ESTIMATION OF YOUR GENERAL HEALTH? (CHECK ONE) ☐ GOOD ☐ FAIR ☐ POOR

CHECK IF YOU ARE: ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOW ☐ WIDOWER

DIRECTIONS

CHECK THE APPROPRIATE BOX - YES OR NO - FOR THE FOLLOWING QUESTIONS?
(PLEASE ANSWER ALL THE QUESTIONS.)

1. HAVE YOU EVER HAD AN INJURY TO YOUR FACE OR JAWS? ☐ YES ☐ NO
2. HAVE YOU BEEN EXAMINED BY YOUR PHYSICIAN WITHIN THE PAST YEAR? ☐ YES ☐ NO
3. ARE YOU BEING TREATED FOR ANY CONDITION BY A PHYSICIAN NOW? ☐ YES ☐ NO
4. HAVE YOU BEEN TAKING ANY MEDICINES WITHIN THE PAST YEAR? ☐ YES ☐ NO
5. HAS THERE BEEN ANY CHANGE IN YOUR GENERAL HEALTH IN THE PAST YEAR? ☐ YES ☐ NO
6. HAVE YOU LOST OR GAINED WEIGHT IN RECENT MONTHS? ☐ YES ☐ NO
7. DO YOU SMOKE? ☐ YES ☐ NO
8. HAVE YOU EVER BEEN SERIOUSLY ILL? ☐ YES ☐ NO
9. HAVE YOU EVER HAD SURGERY? ☐ YES ☐ NO
10. DO YOU TAKE ASPIRIN ON A REGULAR BASIS? ☐ YES ☐ NO
11. WHAT MEDICATIONS ARE YOU CURRENTLY TAKING _____

_____

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50 Hwy. 9 North • Grosso Bldg., Suite 102
Morganville, New Jersey 07751
(732) 972-5922 • Fax (732) 972-6520

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12. Do you have any replacement joints (hip/knee)? ☐ YES ☐ NO

13. Have you ever been hospitalized? ☐ YES ☐ NO

14. Have you ever been treated for a growth or tumor in any part of you body? ☐ YES ☐ NO

15. Have you ever had any of the following diseases or conditions? ☐ YES ☐ NO

A. Jaundice	☐ YES ☐ NO	L. Swollen Ankles	☐ YES ☐ NO
B. Hepatitis	☐ YES ☐ NO	M. Ulcers	☐ YES ☐ NO
C. Tuberculosis	☐ YES ☐ NO	N. Epilepsy	☐ YES ☐ NO
D. Venereal Diseases	☐ YES ☐ NO	O. Diabetes (Sugar Disease)	☐ YES ☐ NO
E. Heart Attack	☐ YES ☐ NO	P. Heart Murmur	☐ YES ☐ NO
F. Stroke	☐ YES ☐ NO	Q. Painful or Swollen Joints	☐ YES ☐ NO
G. High Blood Pressure	☐ YES ☐ NO	R. Persistent Cough	☐ YES ☐ NO
H. Low Blood Pressure	☐ YES ☐ NO	S. Asthma or Hay Fever	☐ YES ☐ NO
I. Chest Pain on Exertion	☐ YES ☐ NO	T. Mitral Valve Prolapse	☐ YES ☐ NO
J. Shortness of Breath	☐ YES ☐ NO	U. HIV	☐ YES ☐ NO
K. Anemia	☐ YES ☐ NO		

16. Do you bleed for a long time when you cut yourself? ☐ YES ☐ NO

17. Do you have any allergies to (food, dust, cats fur, etc.)? ☐ YES ☐ NO

18. Have you ever experienced an unusual reaction to any of the following:.

A. Penicillin	☐ YES ☐ NO
B. Barbiturates (sleeping pills)	☐ YES ☐ NO
C. Aspirin	☐ YES ☐ NO
D. Iodine	☐ YES ☐ NO
E. Sulfa Drugs	☐ YES ☐ NO
F. Codeine	☐ YES ☐ NO
G. Other Medications	☐ YES ☐ NO
H. Latex	☐ YES ☐ NO

19. Have you ever experienced an unusual reaction to a dental anesthetic (novocaine injections)? ☐ YES ☐ NO

20. Do you often have to get up at night to urinate? ☐ YES ☐ NO

21. Are you thirsty much of the time? ☐ YES ☐ NO

22. Do you have any numbness or tingling in any part of your body? ☐ YES ☐ NO

23. Have you ever had any blood transfusions? ☐ YES ☐ NO

24. WOMEN - Are you pregnant at the present time? ☐ YES ☐ NO

25. WOMEN - Have you ever had a miscarriage? ☐ YES ☐ NO

26. WOMEN - Are you taking any hormonal medications/birth control pills? ☐ YES ☐ NO

27. WOMEN - Have you had a Hysterectomy or Ovariectomy? ☐ YES ☐ NO

DATE:_____ SIGNATURE_____