Health Questionnaire_ Medical Alert: Premed: Allergies: Emily J. Schaefer, DDS • Buffalo, NY

Date: _____

Name: _____ Date of birth___/___/___
last first middle

Address: _____
number & street city & state zip

Phone: _____Social Security #: _____
home cell

Sex: _____ Height: _____ Weight: ____ Employer/Occupation: _____

Married: ____ Single: ____ Spouse's Name: _____ # of Children: _____

Closest Relative: _____Phone: _____

Person who referred you to our office: _____

Dental Insurance Company: _____

Personal responsible for bill: Name:_____Phone:_____

Address: _____

Dental History

1) Do your gums bleed when you brush?.....No Yes
2) Are your teeth sensitive to cold, hot, sweets or pressure?.....No Yes
3) Have you had any periodontal (gum) treatments?.....No Yes
4) Have you had any serious or difficult problems with previous dental treatments?.....No Yes
5) Have you ever had orthodontic (braces) treatment?.....No Yes
6) Do you have headaches, ear aches or neck pains?.....No Yes
7) Are you happy with the appearance of your teeth?.....No Yes
8) Would you consider whitening or straightening your teeth?.....No Yes
9) When was your last dental appointment and what services were provided?.....

Medical History:

1) Are you in good health?.....No Yes
   Has there been any change in your health in the past year?
   Date of last physical____/____/____ Physician: Name: _____
   Address: _____
   City/state/zip: _____
   Phone #: _____
2) Have you had any serious illness or operations?.....No Yes
   a) Been hospitalized or seriously ill in the past 5 years……..…… No Yes
3) Do you, or have you, had any of the following diseases or problems?
   a) Rheumatic fever or rheumatic heart disease…….. No Yes
   b) Mitral valve prolapse or heart murmur…….. No Yes
   c) Artificial hip, joint, heart valve, pacemaker, pins, screws, or plates?..... No Yes
   d) Heart trouble, high blood pressure, arteriosclerosis, stroke, coronary insufficiency, heart attack, bypass surgery, angina…….……...No Yes
   e) Allergies…….……....No Yes

f) Asthma or hay fever……...No Yes
g) Hives or skin rash……...No Yes
h) Fainting spells or seizures……...No Yes
i) Diabetes……No Yes
j) Does you mouth get dry often or are you thirsty frequently……...……..No Yes
k) Hepatitis, jaundice, liver disease, Epstein-Barr, or mononucleosis……No Yes
l) Arthritis or inflammatory rheumatism……...No Yes
m) Stomach Ulcers……No Yes
n) Kidney trouble……..No Yes
o) Tuberculosis……No Yes
p) Low blood pressure……..No Yes
q) Venereal disease…….....No Yes
r) H.I.V., A.I.D.S., or A.I.D.S. related complex…….....No Yes

4) Have you had any abnormal bleeding associated with previous extractions, surgery, or trauma?.. No Yes
   a) Do you bruise easily……. No Yes
   b) Have you ever required blood transfusion……..... No Yes
   c) Do you have any blood disorder such as anemia or hemophilia……...…. No Yes
5) Have you had surgery or x-ray therapy for a tumor, growth or other condition of your head or neck……...No Yes
6) Are you taking any of the following
   a) Antibiotics or sulfa drugs……...……No Yes
   b) Anticoagulants or blood thinners…….…..No Yes
   c) Medicine for high blood pressure…….....No Yes
   d) Cortisone or steroids……No Yes
   e) Tranquilizers……..……No Yes
   f) Insulin or medication for blood sugar……No Yes
   g) Aspirin on a regular basis……...No Yes
   h) Nitroglycerin, digitalis, or any drugs for heart trouble……No Yes
   i) Other (please list)……...No Yes
7) Are you allergic or have you had a reaction to:
   a) Local anesthetic ("Novocain")……...No Yes
   b) Penicillin or other antibiotics……No Yes
   c) Sulfa drugs…….....No Yes
   d) Barbiturates, sedatives, or sleeping pills……..……No Yes
   e) Aspirin……...No Yes
   f) Iodine……No Yes
   g) Other medications (Please list)……...No Yes
8) Do you have any disease, condition, or problem not listed above that I should know about……..No Yes
   Please explain_____

Women

1) Are you pregnant…….. No Yes

By signing below, I certify that the above information is correct to the best of my knowledge, and I agree to abide by the office policies for fees and their payment

_____

Signature of Patient (or guardian if under 18)