

# NORTHEAST TEXAS PERIODONTAL SPECIALISTS

## PERIODONTICS & DENTAL IMPLANTS

DIPLOMATE OF THE AMERICAN BOARD OF PERIODONTOLOGY

### HEALTH QUESTIONNAIRE

PHYSICIAN \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_

PHONE \_\_\_\_\_

YOUR AGE \_\_\_\_\_

HEIGHT \_\_\_\_\_

WEIGHT \_\_\_\_\_

MO/YEAR OF YOUR LAST MEDICAL EXAMINATION \_\_\_\_\_

HOW WOULD YOU DESCRIBE YOUR PRESENT HEALTH (CIRCLE ONE): EXCELLENT    GOOD    FAIR    POOR    DON'T KNOW

YES NO ???

- HAS THERE BEEN ANY CHANGE IN YOUR GENERAL HEALTH IN THE PAST YEAR?
- HAVE YOU HAD A SERIOUS ILLNESS, OPERATION OR HOSPITALIZATION DURING THE PAST FIVE YEARS?  
IF YES, PLEASE DESCRIBE \_\_\_\_\_
- ARE YOU TAKING OR HAVE YOU RECENTLY TAKEN ANY OF THE FOLLOWING:  
    PRESCRIBED MEDICATIONS & INHALERS:  
    OVER THE COUNTER, NATURAL OR HERBAL PREPARATIONS:
- HAVE YOU EVER  RECEIVED I.V., OR  TAKEN ORALLY: AREDIA, ZOMETA, FOSAMAX OR ANY OTHER BISPHOSPHONATES ?
- HAVE YOU EVER TAKEN PONDIMIN (FENDLURAMINE), PHEN-FEN (PHENTERMINE) OR REDUX (DEXPHENFLURAMINE) FOR WEIGHT REDUCTION?
- HAS YOUR M.D. TOLD YOU TO TAKE ANTIBIOTICS PRIOR TO HAVING ANY TYPE OF DENTAL PROCEDURE?
- ARE YOU ALLERGIC TO ANY MEDICATIONS OR DRUGS, LATEX, IODINE?
- HAVE YOU EVER HAD ADVERSE REACTION TO ANY DRUGS, ANESTHETICS, SEDATIVES, NARCOTICS, ASPIRIN, IBUPROFEN (MOTRIN)?
- HAVE YOU EVER HAD EXCESSIVE BLEEDING THAT REQUIRED SPECIAL TREATMENT?
- HAVE YOU BEEN DIAGNOSED AS HAVING ANY IMMUNODEFICIENCY, SYSTEMIC LUPUS, ARC OR AIDS?
- IS THERE A HISTORY OF DIABETES IN YOUR FAMILY?
- ARE YOU REQUIRED, DUE TO HEALTH, TO RESTRICT YOUR WORK OR ACTIVITY IN ANY WAY?
- ARE YOU ON A SPECIAL OR RESTRICTED DIET OF ANY KIND? \_\_\_\_\_
- DO YOU USE ANY KIND OF TOBACCO? IF SO HOW MUCH: \_\_\_\_\_ PER DAY, WEEK, MONTH
- DO YOU USE ANY KIND OF ALCOHOL? IF SO HOW MUCH: \_\_\_\_\_ PER DAY, WEEK, MONTH
- DO YOU HAVE ANY HISTORY OF SUBSTANCE ABUSE OR DO YOU CURRENTLY USE RECREATIONAL DRUGS?

FOR WOMEN, CHECK ALL THAT ARE APPROPRIATE:     I AM PREGNANT     I AM NURSING     I AM TAKING BIRTH CONTROL PILLS

CHECK ALL OF THE FOLLOWING THAT YOU MAY HAVE HAD IN THE PAST OR THAT CURRENTLY APPLY TO YOU:

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> CHEST PAIN UPON EXERTION | <input type="checkbox"/> RECEIVED BLOOD TRANSFUSION | <input type="checkbox"/> SLEEP APNEA                | <input type="checkbox"/> HEADACHES                |
| <input type="checkbox"/> SHORTNESS OF BREATH      | <input type="checkbox"/> IMPAIRED LIVER FUNCTION    | <input type="checkbox"/> ASTHMA                     | <input type="checkbox"/> MIGRAINES                |
| <input type="checkbox"/> HIGH BLOOD PRESSURE      | <input type="checkbox"/> KIDNEY DISEASE             | <input type="checkbox"/> BRONCHITIS                 | <input type="checkbox"/> EPILEPSY                 |
| <input type="checkbox"/> LOW BLOOD PRESSURE       | <input type="checkbox"/> IMPAIRED KIDNEY FUNCTION   | <input type="checkbox"/> EMPHYSEMA                  | <input type="checkbox"/> SEIZURES                 |
| <input type="checkbox"/> HEART VALVE PROSTHESIS   | <input type="checkbox"/> ESOPHYGEAL REFLUX          | <input type="checkbox"/> SINUS TROUBLES             | <input type="checkbox"/> MENTAL HEALTH PROBLEMS   |
| <input type="checkbox"/> MITRAL VALVE PROLAPSE    | <input type="checkbox"/> HIATAL HERNIA              | <input type="checkbox"/> PERSISTENT COUGH           | <input type="checkbox"/> RECURRENT INFECTIONS     |
| <input type="checkbox"/> CONGENITAL HEART LESION  | <input type="checkbox"/> G.I. ULCERS                | <input type="checkbox"/> TUBERCULOSIS               | <input type="checkbox"/> WEAR CONTACT LENSES      |
| <input type="checkbox"/> RHEUMATIC FEVER          | <input type="checkbox"/> ANOREXIA OR BULEMIA        | <input type="checkbox"/> JOINT REPLACEMENT SURGERY  | <input type="checkbox"/> SEVERELY IMPAIRED VISION |
| <input type="checkbox"/> HEART MURMUR             | <input type="checkbox"/> IRRITABLE BOWEL SYNDROME   | <input type="checkbox"/> CONNECTIVE TISSUE DISORDER |   |
| <input type="checkbox"/> DAMAGED HEART VALVE      | <input type="checkbox"/> COLITIS                    | <input type="checkbox"/> ARTHRITIS                  |   |
| <input type="checkbox"/> HEART ARRHYTHMIA         | <input type="checkbox"/> DIABETES                   | <input type="checkbox"/> RECENT WEIGHT LOSS         |   |
| <input type="checkbox"/> TACHYCARDIA              | <input type="checkbox"/> OSTEOPOROSIS               | <input type="checkbox"/> CHRONIC FATIGUE            |   |
| <input type="checkbox"/> HEART SURGERY            | <input type="checkbox"/> RADIATION THERAPY          | <input type="checkbox"/> GLAUCOMA                   |   |
| <input type="checkbox"/> CARDIAC PACEMAKER        | <input type="checkbox"/> CHEMOTHERAPY               | <input type="checkbox"/> NEUROLOGICAL DISORDERS     |   |
| <input type="checkbox"/> HEPATITIS OR JAUNDICE    | <input type="checkbox"/> HISTORY OF CANCER          | <input type="checkbox"/> STROKE                     |   |
| <input type="checkbox"/> GLAUCOMA                 |   |   |   |

Do you have any disease, problem or condition not listed above? Yes \_\_\_ No \_\_\_ Please explain: \_\_\_\_\_

Signature of patient or legal guardian \_\_\_\_\_

Date \_\_\_\_\_

Reviewed by \_\_\_\_\_