NORTHEAST TEXAS PERIODONTAL SPECIALISTS

PERIODONTICS & DENTAL IMPLANTS

HEALTH QUESTIONAIRE

PATIENT NAME_____ SIGNATURE_____ DATE_____

YOUR AGE_____ HEIGHT_____ WEIGHT _____ MO/YEAR OF YOUR LAST MEDICAL EXAMINATION _____

PHYSICIAN NAME_____

PHYSICIAN ADDRESS_____ CITY _____ PHONE _____

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 _____
☐	☐	☐	PLEASE LIST ANY CURRENT MEDICATIONS: _____
☐	☐	☐	ARE YOU ALLERGIC TO ANY MEDICATIONS, DRUGS, LATEX, IODINE? _____
☐	☐	☐	HAVE YOU EVER
			☐ RECEIVED I.V BISPHOSPHONATES? (AREDIA, ZOMETA)
			☐ TAKEN ORALLY: ANY OTHER BISPHOSPHONATES ? (FOSAMAX, ACTONEL)
☐	☐	☐	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?
☐	☐	☐	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:

☐ CHEST PAIN UPON EXERTION
☐ SHORTNESS OF BREATH
☐HIGH BLOOD PRESSURE
☐LOW BLOOD PRESSURE
☐HEART VALVE PROSTHESIS
☐MENTAL HEALTH PROBLEMS
☐PERSISTENT COUGH
☐CONGENITAL HEART LESION
☐☐ANOREXIA OR BULEMIA
☐HEART MURMUR
☐HEART ARRTHYMIA
☐CONNECTIVE TISSUE DISORDER
☐HEART SURGERY
☐CARDIAC PACEMAKER
☐HEPATITIS OR JAUNDICE

☐RECEIVED BLOOD TRANSFUSION
☐IMPAIRED LIVER FUNCTION
☐KIDNEY DISEASE
☐IMPAIRED KIDNEY FUNCTION
☐ESOPHYGEAL REFLUX
☐MITRAL VALVE PROLAPSE
☐RECURRENT INFECTIONS
☐JOINT REPLACEMENT SURGERY
☐SEVERELY IMPAIRED VISION
☐IRRITABLE BOWEL SYNDROME
☐RECENT WEIGHT LOSS
☐OSTEOPOROSIS
☐RADIATION THERAPY
☐CHEMOTHERAPY

☐SLEEP APNEA
☐ASTHMA
☐BRONCHITIS
☐EMPHYSEMA
☐SINUS TROUBLES
☐HIATAL HERNIA
☐RHEUMATIC FEVER
☐WEAR CONTACT LENSES
☐DAMAGED HEART VALVE
☐TACHYCARDIA
☐TUBERCULOSIS
☐CHRONIC FATIGUE
☐HISTORY OF CANCER
☐NEUROLOGICAL DISORDERS

☐HEADACHES
☐MIGRAINES
☐EPILEPSY
☐SEIZURES
☐G.I. ULCERS
☐GLAUCOMA
☐COLITIS
☐ARTHRITIS
☐DIABETES
☐STROKE

REVIEWED BY _____ **DATE**_____