

## HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

### Personal Health History

**Name:**  M  F **DOB (MM/DD/YY):**  
**Address:** **City:** **Prov:** **Postal:**  
**CELL:** **WORK:** **HOME:**  
**EMAIL:** **EMPLOYER:**  
**Personal Physician:** **Physician Phone #:**

### Dental Insurance Company

**Name:**  
**Policy Holder Name:**  
**DOB (MM/DD/YY):**  
**Policy/Plan #:**  
**Certificate/Id #:**

### If Under 18

**Parent or Guardians Name:**  
**DOB (MM/DD/YY):**

**The following information is required to thoroughly diagnose any condition and to give the highest possible standard of treatment. All information will be kept strictly confidential.**

1. Are you under the care of a physician? If so, for what condition?
2. Have you been hospitalized in the last 2 years? If so, please explain
3. Are you taking any drugs or medications? If so, please list
4. Do you have any allergies? If so, please list
5. Have you had adverse reactions to any drug, local anesthesia, antibiotics, barbiturates, sedatives or pain killers?

6. Tick any of the following that you have had:

AIDS/HIV <input type="checkbox"/>	Digestive disorders <input type="checkbox"/>	Kidney disease <input type="checkbox"/>	STI <input type="checkbox"/>
Anemia <input type="checkbox"/>	Drug/alcohol dependency <input type="checkbox"/>	Lung disease <input type="checkbox"/>	Sleep apnea <input type="checkbox"/>
Angina <input type="checkbox"/>	Emphysema <input type="checkbox"/>	Lupus <input type="checkbox"/>	Steroid therapy <input type="checkbox"/>
Arthritis <input type="checkbox"/>	Epilepsy [Seizures] <input type="checkbox"/>	Migraines <input type="checkbox"/>	Stomach ulcers <input type="checkbox"/>
Asthma <input type="checkbox"/>	Fibromyalgia <input type="checkbox"/>	Mitral valve prolapses <input type="checkbox"/>	Stroke <input type="checkbox"/>
Blood transfusion <input type="checkbox"/>	Heart trouble <input type="checkbox"/>	Osteoporosis <input type="checkbox"/>	Thyroid disorder <input type="checkbox"/>
Cancer <input type="checkbox"/>	Hepatitis A/B/C <input type="checkbox"/>	Pacemaker <input type="checkbox"/>	Tuberculosis (TB) <input type="checkbox"/>
Cold sores <input type="checkbox"/>	High/low blood pressure <input type="checkbox"/>	Radiation/Chemotherapy <input type="checkbox"/>	Are you a smoker: Y <input type="checkbox"/> N <input type="checkbox"/>
Diabetes: Type 1 <input type="checkbox"/> 2 <input type="checkbox"/>	Hypo/ Hyperglycemia <input type="checkbox"/>	Rheumatic fever <input type="checkbox"/>	Other: <input type="checkbox"/>

7. Have you ever had abnormal bleeding associated with previous surgery, trauma or extractions?

8. Are you pregnant?

9. What dental conditions concern you at present?

10. How did you find out about our office?

This is to certify that I, the undersigned, consent to the dental procedures agreed to be necessary or advisable and will assume responsibility for fees associated with those procedures.

\_\_\_\_\_  
Patient OR Parent/Guardian Signature

\_\_\_\_\_  
Date

**Please be assured that your personal information is for office use and will only be used following PHIA**