DUNKIRK
DENTAL

Health History Questionnaire

Medical History:

Circle below — Do you have (or have you ever had) any of the following?

Clinic Use Only

Yes No Allergic reaction to drugs or latex (circle all that apply):
Latex Penicillin Aspirin Codeine Local Anesthetics Metal Other

Yes No Heart attack or heart disease
Yes No Stroke
Yes No High Blood Pressure
Yes No Congestive Heart Failure
Yes No Angina (chest pains)
Yes No Irregular heart beat
Yes No Artificial heart valve
Yes No Rheumatic fever, rheumatic heart disease
Yes No Bacterial endocarditis (SBE)
Yes No Congenital heart disease
Yes No Heart murmur or mitral valve prolapsed
Yes No Immunosuppressive condition (circle all that apply)
Steroid Therapy (e.g. prednisone) Radiation Therapy Chemotherapy SLE (Lupus)
Rheumatoid Arthritis HIV Organ Transplant Spleen removed Other_____
Yes No Artificial joint(s) - (circle all that apply):
Hip | Knee | Ankle | Shoulder | Other
Date placed:
Yes No Other artificial implants or devices
Yes No Bleeding problem, anemia, other blood disease
Yes No Diabetes
Yes No Thyroid disease
Yes No Nervous system disease or seizures
Yes No Stomach or intestinal disease
Yes No Kidney disease
Yes No Hepatitis (A, B, C or D)
Yes No Other liver disease
Yes No Arthritis
Yes No Other muscle or joint disease
Yes No Asthma
Yes No Tuberculosis
Yes No Other lung disease
Yes No Mental health condition – Specify:_____
Yes No Physical or mental disabilities that may require special care
Yes No Do you have or have you ever been treated for cancer?
Yes No Do you have any disease, condition, or problem not listed here?
Describe: _____
Yes No Do you have any undiagnosed symptoms?
Describe: _____
Yes No Are you, or have you ever been addicted to a chemical substance?
(Examples: alcohol, prescription drugs, heroine, meth, cocaine, other)
Yes No Do you smoke or use tobacco products?
How long have you used tobacco? _____

(over)

Type of tobacco used? _____
How much do you use per day? _____
Are you interested in quitting? ( ) Yes ( ) No

Yes No Are you a past user of tobacco products?

Yes No Do you regularly take herbal medicines or dietary supplements?
Specifically, do you take (circle all that apply):
Echinacea Garlic Ginger Kava Valerian Feverfew Gingko
Ginseng St. John's Wart Vitamin E Other: _____

Yes No Have you undergone current or past osteoporosis therapy?

Clinic Use Only

Physician List (List your family physician and any medical specialists you see at least once a year):

Name	**Address**	**City**	**Phone#**	**Specialty**

Medications you are currently taking:

Medication name	**Pharmacy**	**Pharmacy telephone number**

Dental History:

Chief Complaint: (Why are you seeking dental care?)_____

Circle below

Clinic Use Only

Yes No Do you have regular check-ups?
Date of last dental exam? _____

Yes No Have you had any trouble associated with previous dental treatment?
If so, explain: _____

Yes No Have you noticed any lumps or sores in your mouth?

Yes No Do your gums bleed when you brush your teeth?

Yes No Have you ever injured your face, jaws or teeth?

Yes No Do you suffer from pain in the mouth, face, eyes, neck or throat?

Yes No Are you unhappy with the appearance of your teeth?

Yes No Has fear ever prevented you from seeking dental treatment?

Yes No Are you allergic to any metals or dental materials?

Yes No Circle the types of dental treatment you have experienced:

Orthodontics (braces) Dentures Root canal treatment Implants Oral Surgery
Periodontal (gum) treatment TMJ treatment Fillings Crowns Bridges Veneers
Bleaching Other: _____

Provide any additional medical / dental history information not already covered in this questionnaire:

_____

_____