Aesthetic Periodontal and Implant Therapy

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HEALTH QUESTIONNAIRE

PHYSICIAN ______________________ PHONE __________ MO/YEAR OF YOUR LAST MEDICAL EXAMINATION__________

YOUR NAME____ YOUR AGE ______

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 PREPARATION: ______________________
❑	❑	❑	HAVE YOU EVER TAKEN ANY BISPHOSPHONATES SUCH AS AREDIA, ZOMETA OR FOSAMAX? ❑ ORALLY ❑ I.V.
❑	❑	❑	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 SUCH AS SYSTEMIC LUPUS, HIV (AIDS)?
❑	❑	❑	HAVE YOU BEEN DIAGNOSED WITH LIVER DISEASE SUCH AS HEPATITIS TYPE A, B OR C?
❑	❑	❑	HAVE YOU BEEN DIAGNOSED WITH DIABETES OR IS THERE A HISTORY OF DIABETES IN YOUR FAMILY? ______________
❑	❑	❑	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	☐CARDIAC PACEMAKER	☐RADIATION THERAPY	☐RECENT WEIGHT LOSS
☐SHORTNESS OF BREATH	☐JAUNDICE	☐CHEMOTHERAPY	☐CHRONIC FATIGUE
☐HIGH BLOOD PRESSURE	☐RECEIVED BLOODTRANSFUSION	☐HISTORY OF CANCER	☐GLAUCOMA
☐LOW BLOOD PRESSURE	☐IMPAIRED LIVER FUNCTION	☐SLEEP APNEA	☐NEUROLOGICAL DISORDERS
☐HEART VALVE PROSTHESIS	☐KIDNEY DISEASE	☐ASTHMA	☐STROKE
☐MITRAL VALVE PROLAPSE	☐IMPAIRED KIDNEY FUNCTION	☐BRONCHITIS	☐HEADACHES
☐CONGENITAL HEART LESION	☐ESOPHYGEAL REFLUX	☐EMPHYSEMA	☐MIGRAINES
☐RHEUMATIC FEVER	☐HIATAL HERNIA	☐SINUS TROUBLES	☐EPILEPSY
☐HEART MURMUR	☐G.I. ULCERS	☐PERSISTENT COUGH	☐SEIZURES
☐DAMAGED HEART VALUE	☐ANOREXIA OR BULEMIA	☐TUBERCULOSIS	☐MENTAL HEALTH PROBLEMS
☐HEART ARRTHYMIA	☐IRRITABLE BOWEL SYNDROME	☐JOINT REPLACEMENT SURGERY	☐RECURRENT INFECTIONS
☐TACHYCARDIA	☐COLITIS	☐CONNECTIVE TISSUE DISORDER	☐WEAR CONTACT LENSES
☐HEART SURGERY	☐OSTEOPOROSIS	☐ARTHRITIS	☐SEVERELY IMPAIRED VISION

Do you have any disease, problem or condition not listed above? Please explain: ______________________

______________________ ____________ ______________________

Signature of patient or legal guardian Date Reviewed by