Health Questionnaire

Konard O. Hauffe, DDS

717 Main Ave, Brookings SD

Patient's Name _____ Birthdate _____

Dental History Information:

Doctors Remarks

Date	Systolic	Diastolic	Initial

(YES NO) 1. Are you having any discomfort at this time?

(YES NO) 2. Have you had any serious trouble associated with previous dental treatments?

If so, please explain: _____

3. Does dental treatment make you nervous? No___ Slightly ___ Moderately ___ Extremely ___

4. Date of last dental visit: _____

5. Date of last full mouth series or panoramic xrays: _____

(YES NO) 6. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? when? _____

7. Do you have or have you had any of the following:

Mouth			**Teeth**		
Bleeding,. sore gums	yes	no	Loose teeth	yes	no
Unpleasant taste/bad breath	yes	no	Sensitive to hot	yes	no
Burning tongue/lips	yes	no	Sensitive to cold	yes	no
Frequent blisters, lips/mouth	yes	no	Sensitive to sweets	yes	no
Swelling/ lumps in mouth	yes	no	Sensitive to biting	yes	no
Ortho treatment (braces)	yes	no	Food impaction	yes	no
Biting cheeks/lips	yes	no	Clenching/grinding	yes	no
Clicking/popping jaw	yes	no	If so, when_____		
Difficulty opening or closing jaw	yes	no	Shifting in bite	yes	no
Change in bite	yes	no			

8. Do you use the following? How often?

(YES NO) Toothbrush: _____

(YES NO) Dental Floss: _____

(YES NO) Fluoride Rinse/Toothpaste: _____

(YES NO) Other: _____

9. Name and address of your previous dentist: _____

_____

_____

(YES NO) 10. Is it important for you to keep your teeth?

Medical History Information:

(YES NO) 1. Has there been any change in your general health within the past year?

If so, describe: _____

(YES NO) 2. My last physical examination was on _____

(YES NO) 3. Are you now under the care of a physician?

If so, what is the condition being treated _____

4. What is the name of your physician? _____

(YES NO) 5. Have you had any serious illness within the past five years?

If so, what was the illness _____

(YES NO) 6. Have you been hospitalized or had an operation within the past five years?

If so, what was the problem _____

7. Do you have or have you had any of the following diseases or problems?

(YES NO) – a. Rheumatic fever or rheumatic heart disease

(YES NO) – b. Congenital heart disease / Heart Murmer

(YES NO) – c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, High/low blood pressure, arteriosclerosis, stroke, other)

(YES NO) – - (1) Do you have pain in chest upon exertion

(YES NO) – - (2) Are you ever short of breath after mild exercise

(YES NO) – - (3) Do your ankles swell

(YES NO) – - (4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep?

(YES NO) _ d. Artificial or replacement valves

(YES NO) – e. Pacemaker

(YES NO) – f. Sinus trouble

(YES NO) – g. Asthma or hay fever

(YES NO) – h. Hives or a skin rash

(YES NO) – i. Fainting spells or seizures

(YES NO) – j. Diabetes

(YES NO) – - (1) Do you have to urinate (pass water) more than six times a day

(YES NO) – - (2) Are you thirsty most of the time

(YES NO) – - (3) Does your mouth frequently become dry

(YES NO) _ k. Hepatitis, jaundice or liver disease

(YES NO) _ l. Arthritis or inflammatory rheumatism

(YES NO) _ m. Artificial or replacement joints, prosthetic

(YES NO) _ n. Digestive system—Ulcers or stomach disorders (colitis)

(YES NO) _ o. Kidney trouble

(YES NO) _ p. Tuberculosis

(YES NO) _ q. Persistent cough or cough up blood

(Over – Continue)

7. Continued:

(YES NO) _ r. Head, neck, or back pain or limitations on movement
(YES NO) _ s. Glaucoma
(YES NO) _ t. Immune System disorders (including AIDS, HIV, ARC)
(YES NO) _ u. Venereal disease

Other _____

(YES NO) 8. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma?
(YES NO) _ a. Do you bruise easily?
(YES NO) _ b. Have you ever required a blood transfusion?

If so, explain the circumstances and when _____

(YES NO) 9. Have you ever tested positive for the AIDS virus?
(YES NO) 10. Do you have any blood disorder such as anemia?
(YES NO) 11. Have you had surgery or x-ray treatment for a tumor, growth, or other condition?
(YES NO) 12. Are you taking any of the following? If "Yes" to any of the following, state drug name, dosage, and frequency:
(YES NO) _ a. Antibiotics or sulfa drugs - - - :_____
(YES NO) _ b. Anticoagulants (blood thinners) - :_____
(YES NO) _ c. Medicine for high blood pressure - :_____
(YES NO) _ d. Cortisone (steroids) - - - - - :_____
(YES NO) _ e. Tranquilizers - - - - - - - - :_____
(YES NO) _ f. Antihistamines - - - - - - - - :_____
(YES NO) _ h. Insulin, tolbutamide (Orinase) or similar drug for diabetes:_____
(YES NO) _ i. Digitalis or drugs for heart trouble - :_____
(YES NO) _ j. Nitroglycerin - - - - - - - - :_____
(YES NO) _ k. Any other medications- - - - - :_____
(YES NO) 13. Are you allergic to or have you reacted adversely to any of the following medications or substances ? Describe:
(YES NO) _ a. Local anesthetics- - - - - - - - :_____
(YES NO) _ b. Penicillin or other antibiotics - - - :_____
(YES NO) _ c. Sulfa drugs - - - - - - - - :_____
(YES NO) _ d. Barbiturates, sedatives, or sleeping pills :_____
(YES NO) _ e. Aspirin - - - - - - - - - - :_____
(YES NO) _ f. Iodine - - - - - - - - - - - :_____
(YES NO) _ g. Codeine or other narcotics - - - - :_____
(YES NO) _ h. Latex - - - - - - - - - - - :_____
(YES NO) _ i. Fruit / Foods - - - - - - - - :_____
(YES NO) _ j. Environmental substances / chemicals :_____
(YES NO) _ 1. Metals - - - - - - - - - - :_____
(YES NO) _ k. Other - - - - - - - - - - :_____

(YES NO) 14. Do you use any tobacco products?

If so, how much per day and what kind _____

(YES NO) 15. Do you use any alcohol products?

If so, how much per day/week/month and what kind _____

(YES NO) 16. Do you use any caffeinated products(coffee, tea, chocolate, etc)

If so, how much per day and what _____

(YES NO) 17. Do you have any disease, condition, or problem not listed previously that you think I should know about ?

If so, explain: _____

(YES NO) 18. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation ?
(YES NO) 19. Are you wearing contact lenses?
(YES NO) 20. Are you experiencing stress or pressure in your work or at home?
(YES NO) 21. Do you have a problem with incontinence? Are you catheterized?

If so, explain: _____

(YES NO) 22. Do you experience dizziness / "light-headedness" when you stand up or lie down?

If so, explain: _____

(YES NO) 23. Have you ever been treated for osteoporosis or have you ever taken Bisphosphonate type medications?

If so, when started _____duration _____ name of medication _____

WOMEN:

(YES NO) 24. Are you pregnant?
(YES NO) 25. Do you have PMS or problems associated with your menstrual period?
(YES NO) 26. Are you taking a birth control or hormone therapy?

To the best of my knowledge, all the preceding answers are true and correct. If I ever have a change in my health or a change in my medication, I will inform the dentist at my next appointment.

Date	Health Reviewed Change	Chart & Accurate No Change	Initial

_____
Signature of Patient Date

_____
Signature of Dentist Date

Additional notes: