



## QUESTIONNAIRE

Name: \_\_\_\_\_ Date: \_\_\_\_\_

### ORAL HABITS

Y - N

Do you:

- Smoke cigarettes, or chew tobacco or use snuff?
- Drink alcohol?
- Drink sugary drinks frequently?
- Currently use any dental whitening product?

### HEALTH HISTORY

Physician's Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

### CARDIOVASCULAR

Yes - No

Do you have or ever had :

- 1   Heart trouble? or prolapsed mitral valve?
- 2    High or  Low blood pressure?
- 3   A heart murmur of any cause?
- 4   Do you take antibiotics before dental treatment ?
- 5   An stroke?

### RESPIRATORY

Do you have or ever had :

- 1   Asthma, hay-fever, sinusitis and/or sore throats ?
- 2   Chronic cough or cough up blood?
- 3   Bronchitis or emphysema?

### NEUROLOGIC AND ENDOCRINE

- 1   Have you ever been under psychiatric care ?
- 2   Do you have numbness or tingling anywhere?
- 3   Do you have diabetes?
- 4   Do you have thyroid issues/ take thyroid tablets?

### G-I AND G-U

- 1   Have you had jaundice, liver trouble or hepatitis?
- 2   Do you have chronic acid reflux or vomiting?
- 3   Have you ever had kidney or bladder trouble?
- 4   Have you had sexually transmitted diseases ?  
(syphilis, gonorrhea, genital herpes, HIV/AIDS)

### HEMATOLOGY AND IMMUNOLOGY

- 1   Have you had anemia ? Do you bruise /bleed easily ?
- 2   Do you have leukemia?
- 3   Are you sensitive or allergic to any medication?  
(penicillin, sulfa drugs, aspirin, etc.)
- 4   Do you have defective immune system?

### MUSC-SKEL

Yes - No

- 1   Do you have arthritis? back problems?
- 2   Do you have osteoporosis? Do you take medications?

### IMPLANTS

Do you have:

- 1   An artificial heart valve?
- 2   A pacemaker or defibrillator?
- 3   Any other implant or prosthetic joint ?

### SURGERY-ANESTHESIA

Have you ever had:

- 1   An operation?, Anesthesia ? Local— General—
- 2   A cancer or a tumor?
- 3   Radiation therapy or chemotherapy?
- 4   An organ/ bone marrow transplant?
- 5   Are you an active/ recovering substance abuser?

### FACIAL PAIN

- 1   Do you have a history of head or neck injury?
- 2   Have you ever had severe pain of the face /head?
- 3   Do you suffer from headache, eye pain or migraine?
- 4   Do you have ear pain or pain in front of your ears?
- 5   Does anything hurt when you chew?
- 6   Does the pain interfere with your work activities?

### FOR WOMEN ONLY

- 1   Are you taking birth control pills?
- 2   Are you pregnant? Expected delivery date \_\_\_\_\_
- 3   Are you breast feeding?

I verify that, to the best of my knowledge, the above information is correct.

\_\_\_\_\_  
**Patient's Signature**

DO NOT WRITE BELOW THIS LINE

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NOTES