DENTAL CARE ASSOCIATES

720 N. Sycamore Avenue
Sioux Falls, SD 57110
(605) 338-6118

Health Questionnaire

Patient Name: _____ Birthdate:_____

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Circle yes or no, whichever applies, in response to the following questions. Your answers are for our records and will be considered confidential.

Dental

1. Are you having any discomfort at this time? ..... Yes No
2. Have you ever had any serious trouble associated with previous dental treatment? ..... Yes No
   If so, explain _____
3. Date of last dental visit _____
4. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? ..... Yes No
   If so, when? _____
5. How often do you brush? _____ Brush is: ☐ Soft ☐ Medium ☐ Hard

Mouth

6. Do you or have you ever had any of the following?

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 treatments (braces)	Yes	No	Food impaction	Yes	No
Biting cheeks/lips	Yes	No	Clenching/grinding	Yes	No
Clicking/popping jaw	Yes	No	If so, when _____	Yes	No
Difficulty opening or closing jaw	Yes	No	Change in bite	Yes	No

7. Do you use the following? ☐ Brush ☐ Dental floss ☐ Fluoride rinse ☐ Other _____
8. Are you satisfied with the appearance of your teeth? ..... Yes No

Medical

1. Name and address of your physician _____
2. Has there been any change in your general health within the past year? ..... Yes No
3. When was your last physical examination? _____
4. Are you now under the care of a physician? ..... Yes No
   If so, what is the condition being treated? _____
5. Do you have or have you had any of the following diseases or problems?
   a) Rheumatic fever or rheumatic heart disease ..... Yes No
   b) Congenital heart disease ..... Yes No
   c) Cardiovascular disease (heart problems, heart attack, coronary insufficiency, coronary occlusion, high/low blood pressure, arteriosclerosis, stroke, etc. ..... Yes No
   d) Artificial or replacement valves ..... Yes No
   e) Mitral valve prolapse ..... Yes No
   f) Pacemaker ..... Yes No
   g) Allergy ..... Yes No
   h) Sinus problems ..... Yes No
   i) Asthma or hay fever ..... Yes No
   j) Hives or a skin rash ..... Yes No
   k) Fainting spells or seizures ..... Yes No
   l) Diabetes ..... Yes No

(over)

m) Hepatitis, jaundice or liver disease ..... Yes No
n) Arthritis or inflammatory rheumatism ..... Yes No
o) Artificial or replacement joints, prosthetic ..... Yes No
p) Digestive system - ulcers or stomach disorders (colitis) ..... Yes No
q) Kidney problems ..... Yes No
r) Tuberculosis ..... Yes No
s) Immune system disorders (including AIDS, HIV) ..... Yes No
t) Sexually transmitted disease ..... Yes No
u) Other _____

6. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? ..... Yes No
7. Have you ever tested positive for the AIDS virus? ..... Yes No
8. Do you have any blood disorder such as anemia? ..... Yes No
9. Have you had surgery or x-ray treatment for a tumor, growth, or other condition? ..... Yes No
10. Are you taking any of the following?
    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
    g) Aspirin ..... Yes No
    h) Insulin, tolbutamide (Orinase) or similar drug for diabetes ..... Yes No
    i) Digitalis or drugs for heart problems ..... Yes No
    j) Nitroglycerin ..... Yes No
    k) Other medications _____
    l) If "yes" to any of above, state drug name, dosage and frequency _____
11. Are you allergic or have reacted adversely to:
    a) Local anesthetics ..... Yes No
    b) Penicillin or other antibiotics ..... Yes No
    c) Aspirin ..... Yes No
    d) Codeine or other narcotics ..... Yes No
    e) Other _____
12. Do you smoke or use tobacco products? ..... Yes No
13. Do you have any disease, condition, or problem not listed above that you think I should know about? ..... Yes No
14. Are you pregnant? ..... Yes No
15. Have you ever taken a bisphosphonate drug, antiresorptive drug or antiangiogenic drug? ..... Yes No

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

_____ _____

Signature of Patient or Parent Date Signature of Dentist Date

Date	Medical Update	Initial