Mountain View Dental Care

HEALTH QUESTIONNAIRE

(Please print)

Are you or have you been under a physician's care in the past year, and if so, for what reason?

Yes No _____

Have you had any major illness, operation, or hospitalization? Yes No

Please list _____

Are you currently taking any medications? Yes No If yes, please list: _____

_____

Do you take aspirin on a daily basis? Yes No

Have you taken antibiotics within the last six months for any reason? Yes No

Are you allergic or have you reacted adversely to latex, local anesthetic? Yes No ____

Have you ever had treatment for drug, alcohol, or eating problems? Yes No

Do your gums bleed? Yes No

Do you have a tendency for prolonged bleeding? Yes No

Do you snore? Yes No

Do you have sleep apnea? Yes No Use a c-pap machine? Yes No

Do you have any apprehension concerning dental treatment? Yes No

If yes, circle one: Slight Moderate Severe

Have you had any of the following?

Heart disease or Heart surgery	Yes	No	Detached retina/Glaucoma	Yes	No
Rheumatic Fever	Yes	No	Epilepsy	Yes	No
Heart Murmur/ Mitral Valve	Yes	No	Liver disease	Yes	No
Heart Attack/Failure	Yes	No	Hepatitis A B or C (Circle)	Yes	No
Artificial Heart Valve	Yes	No	Stomach ulcer	Yes	No
Joint Replacement or Implant	Yes	No	Kidney problems	Yes	No
High/Low Blood Pressure	Yes	No	Thyroid problems	Yes	No
Stroke	Yes	No	Arthritis	Yes	No
Hearing Problems/Aides	Yes	No	Excessive bleeding	Yes	No
Osteoporosis	Yes	No	Lung disease	Yes	No
Tuberculosis (TB)	Yes	No	Sinus problems	Yes	No
Asthma/emphysema	Yes	No	Psychiatric Treatment	Yes	No
Depression/Anxiety	Yes	No	Frequent Headaches/Migraines	Yes	No
Scarlet Fever	Yes	No	Frequent Nosebleeds	Yes	No
Acid Reflux/GERD	Yes	No	Bruise Easily	Yes	No
Cancer or radiation therapy	Yes	No	Smoke or use chewing tobacco	Yes	No
Sexually transmitted diseases	Yes	No	If so, how many packs per day? _____		
HIV positive, AIDS	Yes	No	Diabetes Type1 or Type 2 (circle)		
WOMEN: Are you pregnant?	Yes	No	Are you nursing?	Yes	No

Do you have reaction or allergy to :

Aspirin	Acetaminophen
Penicillin	Ibuprofen
Erythromycin	Halcion
Tetracycline	Sedatives
Codeine	Iodine
Sulfa Drugs	Epinephrine
Latex	Dental Anesthetic
Amoxicillin	Clindamycin

Any Other Medications (List) _____

Food Allergies (List) _____

Physicians Name _____

Phone number _____

Date of Last Check Up _____

List all medications you are taking: _____

_____

_____