

# Health Questionnaire

**Please note:** This information is confidential and important to us so that we can provide the best possible care for you.

**Name:** \_\_\_\_\_

**Age:** \_\_\_\_\_ **Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

If you are completing this for another person what is your relationship to that person? \_\_\_\_\_

	Yes	No
1. Have you been a hospitalized patient during the past 2 years?		
2. Have you been treated for any medical problem during the past 2 years?		
3. Are you taking any drugs or medications at this time? Please list all medications and dosage on the reverse side.		
4. Are you allergic to penicillin?		
5. Are you allergic to any other drugs or medications? If Yes, what?		
6. Have you ever had excessive bleeding following dental treatment or at any time?		
7. (Women) Are you pregnant?		

8. Please check any of the following which you have had:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> heart trouble       | <input type="checkbox"/> hepatitis            | <input type="checkbox"/> epilepsy                          |
| <input type="checkbox"/> heart murmur        | <input type="checkbox"/> kidney disease       | <input type="checkbox"/> venereal disease                  |
| <input type="checkbox"/> rheumatic fever     | <input type="checkbox"/> tuberculosis         | <input type="checkbox"/> ulcers                            |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> respiratory problems | <input type="checkbox"/> A.I.D.S.                          |
| <input type="checkbox"/> diabetes            | <input type="checkbox"/> sinus trouble        | <input type="checkbox"/> artificial heart valves or joints |
| <input type="checkbox"/> tested HIV positive | <input type="checkbox"/> cancer               |  |

9. Is there anything else in your health history that may be significant?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Date:** \_\_\_\_\_

\_\_\_\_\_  
**Signature (patient or parent)**