PATIENT HEALTH QUESTIONS

PATIENT NAME ____________________ CHART # ____________

		YES	NO
1.	**HAVE YOU EVER HAD ROOT CANAL TREATMENT?** ____	☐	☐
2.	**DO YOU HAVE OR HAVE YOU EVER BEEN TREATED FOR:**		
	a. HEART TROUBLE; RHEUMATIC FEVER; MITRAL VALVE PROLAPSE; ARTIFICIAL HEART VALVE; OR HEART MURMER? **(IF SO, CIRCLE WHICH ONE)** ____	☐	☐
	b. HIGH BLOOD PRESSURE? ____	☐	☐
	c. DIABETES? ____	☐	☐
	d. KIDNEY DISEASE? ____	☐	☐
	e. HEPATITIS, LIVER DISEASE? ____	☐	☐
	f. TUBERCULOSIS? ____	☐	☐
	g. HERPES? ____	☐	☐
	h. AIDS, HIV POSITIVE OR POSITIVE FOR AIDS VIRUS? **(CIRCLE)** ____	☐	☐
	i. ARTIFICIAL JOINTS OR IMPLANTS? ____	☐	☐
	j. LUNG DISEASES; ASTHMA, BRONCHITIS, EMPHYSEMA? **(CIRCLE)** ____	☐	☐
	k. EPILEPSY, MULTIPLE SCLEROSIS OR GLAUCOMA? **(CIRCLE)** ____	☐	☐
	l. ULCER? ____	☐	☐
3.	**HAVE YOU EVER EXPERIENCED OR BEEN TOLD YOU HAVE:**		
	a. **TMJ** (TEMPOROMANDIBULAR JOINT DISEASE) OR **CLICKING** OF THE **JAW? (CIRCLE)** ____	☐	☐
	b. **DIFFICULTY OPENING** OR **MUSCLE SPASMS** IN YOUR JAW? **(CIRCLE)** ____	☐	☐
4.	**DIFFICULTY BREATHING** THROUGH YOUR NOSE? ____	☐	☐
5.	HAVE YOU EVER HAD **PROLONGED BLEEDING** FROM AN INJURY, TOOTH EXTRACTIONS, etc? ____	☐	☐
6.	HAVE YOU EVER HAD A **REACTION** FROM A **LOCAL ANESTHETIC**? ____	☐	☐
7.	HAVE YOU EXPERIENCED ANY **ILLNESS** OR **COMPLICATIONS** FOLLOWING **DENTAL TREATMENT** OF ANY KIND? ____	☐	☐
	EXPLAIN: ____		
8.	ARE YOU **ALLERGIC** TO ANY **DRUGS, MEDICATIONS** OR TO **LATEX? (LIST)** ____	☐	☐
9.	ARE YOU TAKING ANY **DRUGS, MEDICATIONS, HERBAL SUPPLEMENTS OR VITAMINS** AT THIS TIME? **(LIST)** ____	☐	☐
10.	ARE YOU OR HAVE YOU **EVER TAKEN** MEDICATION TO **HELP PREVENT OSTEOPOROSIS**, SUCH AS:	☐	☐
	CIRCLE: FOSAMAX ACTONEL BONIVA ZOMETA AREDIA OR OTHER BISPHOSPHONATES		
11.	DO YOU HAVE A HISTORY OF **CHEMICAL DEPENDENCY?** ____	☐	☐
12.	DID YOU HAVE ANY **ALCOHOLIC BEVERAGES** TODAY? ____	☐	☐
13.	DO YOU HAVE, OR HAVE YOU RECENTLY HAD, ANY EVIDENCE OF **INFECTIONS** OR **SORE THROAT?** ____	☐	☐
14.	HAVE YOU BEEN **HOSPITALIZED** OR UNDER THE **CARE OF A PHYSICIAN** THIS PAST YEAR? ____	☐	☐
15.	DO YOU HAVE ANY **DISEASE, CONDITION** OR PROBLEM **I SHOULD KNOW ABOUT**? ____	☐	☐
	(EXPLAIN) ____		
16.	**WOMEN:** ARE YOU PREGNANT? ____ MONTHS ____ TAKING BIRTH CONTROL PILLS? ____	☐	☐
17.	**HAVE YOU EVER HAD A ROOT CANAL BY ONE OF OUR DOCTORS?** ____	☐	☐
	IF YES, BY WHOM? ____ DO YOU KNOW WHEN? ____		
18.	WHAT IS THE IMPRESSION OF YOUR PRESENT HEALTH: ☐ **GOOD** ☐ **FAIR** ☐ **POOR**		

MY ANSWERS TO THE ABOVE QUESTIONS ARE TRUE TO THE BEST OF MY KNOWLEDGE.

PATIENT / GUARDIAN SIGNATURE ____________________ DATE: ____________

ATTENDING DOCTOR SIGNATURE ____________________