



Clermont Family Dentistry

Health Questionnaire

Name: _____ Date: _____

Address: _____ City _____ ST _____ Zip _____

DOB: _____ Home phone: _____ Cell: _____

Email: _____ Best method of contact: Home Mobile Email

Social Security #: _____ Male Female

Married Spouse's Name: _____ Single Parents name: _____

CIRCLE ANY OF THE FOLLOWING THAT YOU CURRENTLY HAVE OR HAVE HAD:

Date of last dental visit: _____ Reason for this visit: _____

AIDS or HIV

Allergies:

___ Latex

___ Penicillin

___ Codeine

Anemia

Arthritis

Artificial Joints/Pins

Asthma

Blood Disease

Blood Thinners

Cancer

Chemotherapy

Diabetes

Drug Addiction

Epilepsy

Emphysema

Excessive Bleeding

Glaucoma

Head Injuries

Heart Disease

Heart Murmur

Hepatitis: type _____

Herpes Infection

Hemophilia

High/Low Blood Pressure

Jaundice

Kidney Disease

Liver Disease

Mental Health

Nervous Disorder

Pacemaker

Pregnancy: Due date: _____

Radiation Treatment

Respiratory problems

Rheumatic Fever

Rheumatism

Sinus Problems

Stomach Problems

Stroke

Tuberculosis

Thyroid Disease

Tumors

Ulcers

Venereal Disease

Other: _____

Have you ever had any complications following dental treatment? Yes

No

If yes, please

explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? Yes No

If yes, please

explain: _____

Are you now under the care of a physician? Yes No

If yes, please explain: _____

Name of Physician: _____ Phone: _____

How do you feel about your smile? _____

CONTINUED ON BACK

Do you have any health problems that need further clarification? If yes, please explain: _____	Yes	No
Are you currently taking any medications? If yes, please explain: _____	Yes	No
Are you or have you ever taken medication for osteoporosis?	Yes	No
Do you take Aspirin, Motrin or Tylenol daily?	Yes	No
Do you premed with antibiotics for dental appointments?	Yes	No
Have you ever bled excessively after dental appointment?	Yes	No
Do you ever have pain in your chest upon exertion?	Yes	No
Has there been a change in your general health in the last year?	Yes	No
Do your ankles swell?	Yes	No
Woman; Are you pregnant now? (if unsure please answer yes)	Yes	No
Are you taking Birth Control?	Yes	No
Do you anticipate becoming pregnant?	Yes	No
Are you a nursing mother?	Yes	No
Do you have a nasal obstruction?	Yes	No
Have you had dental x-rays taken in the past year?	Yes	No
Have you had an injury/surgery to your jaw or face?	Yes	No
Have you ever fainted in the dental office?	Yes	No
Do you use alcohol? Yes No How often? _____		
Do you use tobacco in any form?	Yes	No
Chew Dip Cigarettes Cigars Pipe		
Do you have a cold or respiratory infection now?	Yes	No
Have you ever had a reaction to dental anesthetic?	Yes	No

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend/relative Dental Office
 News Leader Google Insurance Network Facebook Other _____
Name of person or office referring you to our practice: _____

Responsible Party/Insurance Policy Holder Information

Name: _____ Male Female
Social Security #: _____ Date of Birth: _____
Address: _____
_____ Phone Number: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail. I will not hold my dentist or any member of his/her staff, responsible for any error or omissions that I may have made in the completion of the form.

Signature: _____ Date: _____
Signature of patient, parent or guardian

REVIEWED MEDICAL HISTORY BY DENTIST

SIGNATURE: _____