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? Yes No
If yes, please explain:_____

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

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:_____