WCD
WhiteClay
DENTAL
12 POLLY DRUMMOND HILL ROAD • NEWARK, DE 19711-5703
302-731-4225

HEALTH QUESTIONNAIRE

Section A

Patient Name _____ Date of Birth _____

Physician's name and address _____

_____ Last physical exam _____

Major dental problem or reason for seeking treatment _____

_____

Date of last dental x-rays _____

Section B

Please answer all questions by circling "YES" or "NO" and fill in all blank spaces.

1. NO YES Has there been any change in your general health within the past year?
2. NO YES Are you now under the care of a physician? For what condition?

   _____
3. NO YES Have you been hospitalized or had a serious illness during the past five years? If yes, please explain. _____

   _____
4. NO YES Have you ever used bisphosphonate medication?
5. Circle any of the following which you have had or have at the present:

Heart Failure	Diabetes	Other: _____
Heart Disease or Attack	Thyroid Disease	_____
Angina Pectoris	Radiation Treatment	_____
High Blood Pressure	Chemotherapy (cancer)	
Low Blood Pressure	Arthritis/Rheumatism	
Endocarditis	Glaucoma	
Congenital Heart Problem	AIDS/HIV Infection	
Artificial Heart Valve	Hepatitis	
Heart Pacemaker	Blood Transfusion	
Artificial Joint	Drug or Alcohol Abuse	
Anemia	Hemophilia	
Stroke	Venereal Disease (Syphilis/Gonorrhea)	
Kidney Trouble/Dialysis	Epilepsy or Seizures	
Stomach Ulcers	Fainting or Dizzy Spells	
Emphysema	Psychiatric Treatment	
Cough	Excessive Bleeding	
Tuberculosis	Bruise Easily	
Asthma	Osteoporosis	
Sinus Trouble		
Allergies or Hives		

(OVER)

Section C

6. NO YES Are you currently taking any medications?

List: _____

_____

_____

Section D – FOR FEMALES ONLY

7. NO YES Are you pregnant or anticipating pregnancy in the near future?
8. NO YES Are you taking any hormones or birth control pills?

Section E

9. NO YES Do you have any drug allergies?

List: _____

_____

_____

Section F – Oral Health History

10. NO YES Do you have a history of fever blisters, cold sores, or mouth ulcers?
11. NO YES Have you had any trouble with any previous dental treatment?
12. NO YES Do you bleed excessively after extractions, surgery, or wounds?
13. NO YES Do you have a dry mouth frequently?
14. When was your last visit to the dentist? _____

Section G – Dental Questionnaire

15. NO YES Are you in any pain or discomfort at the present time?
16. NO YES Are you dissatisfied with the appearance of your teeth?
17. NO YES Do you have problems chewing satisfactorily?
18. NO YES Is your bite uncomfortable?
19. NO YES Do your gums bleed?
20. NO YES Do you have a bad taste or bad breath?
21. NO YES Does food pack between your teeth?
22. NO YES Are your teeth loose?
23. NO YES Do you clench or grind your teeth together?
24. NO YES Do you have clicking or popping in your jaw joint or ears when you open or close your jaw?
25. NO YES Are your teeth sensitive to hot or cold?
26. NO YES Do you use mouthwash or mouth rinses?
27. NO YES Have you ever had orthodontic treatment?
28. NO YES Have you ever had periodontal treatment (gum surgery / deep cleaning)?
29. NO YES If you have removable partial dentures are they satisfactory?

Signature of patient _____ Date ____/____/____

For office use

Summary of medical history and dental management considerations

Signature of dentist _____

Medical History Update

(OVER)

Medical History Update Continued