White Clay Dental Associates, P.A.

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 _____ for office use: pt# _____

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. Circle any of the following which you have had or have at the present:

Heart Failure	Sinus Trouble
Heart Disease or Attack	Allergies or Hives
Angina Pectoris	Diabetes
High Blood Pressure	Thyroid Disease
Low Blood Pressure	Radiation Treatment
Heart Murmur	Chemotherapy (cancer)
Rheumatic Fever	Arthritis/Rheumatism
Congenital Heart Problem	Glaucoma
Artificial Heart Valve	AIDS/HIV Infection
Mitral Valve Prolapse	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

5. NO YES Do you have chest pain or shortness of breath after mild exercise?
6. NO YES Do you have excessive thirst or frequent urination?

(OVER)

7. NO YES Have you had recent weight loss or persistent diarrhea?
8. NO YES Have you had persistent swollen glands in the neck?
9. NO YES Do you have any disease, condition, or problem not listed?

_____

Section C

Have you taken any of the following drugs or medications in the past six months:

10. NO YES Anticoagulants (blood thinners)
11. NO YES Medicine for high blood pressure or water pills
12. NO YES Cortisone (steroids)
13. NO YES Valium, Librium, or other tranquilizers
14. NO YES Aspirin
15. NO YES Insulin or pills for diabetes
16. NO YES Digitalis or other drugs for heart trouble
17. NO YES Nitroglycerin
18. NO YES Dilantin
19. NO YES Bisphosphonates (Fosamax, Bonefos, etc.) for osteoporosis or cancer (taken anytime in your life)
20. NO YES Other _____

Section D – FOR FEMALES ONLY

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

Section E

23. Circle any drugs you are allergic to or have you had a reaction to:

Novocaine or dental anesthetic	Erythromycin
Penicillin	Aspirin
Tetracycline	Codeine or other narcotics

Other _____

Section F – Oral Health History

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

Section G – Dental Questionnaire

29. NO YES Are you in any pain or discomfort at the present time?
30. NO YES Are you dissatisfied with the appearance of your teeth?
31. NO YES Do you have problems chewing satisfactorily?
32. NO YES Is your bite uncomfortable?
33. NO YES Do your gums bleed?
34. NO YES Do you have a bad taste or bad breath?
35. NO YES Does food pack between your teeth?

36. NO YES Are your teeth loose?
37. NO YES Do you clench or grind your teeth together?
38. NO YES Do you have clicking or popping in your jaw joint or ears when you open or close your jaw?
39. NO YES Are your teeth sensitive to hot or cold?
40. NO YES Do you use mouthwash or mouth rinses?
41. NO YES Have you ever had orthodontic treatment?
42. NO YES Have you ever had periodontal treatment?
43. 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)