HEALTH QUESTIONNAIRE:

Patient Name:_____
Birthdate: ___/___/___
Today's date: ___/___/___
Name or person completing form if different from patient:_____

PLEASE ANSWER BY CIRCLING YES (Y) OR NO (N) FOR EACH INDIVIDUAL QUESTION.

1.	Are you in good health?	Y	N
2.	Has there been any change in your general health in the past year?	Y	N
3.	Do you require **antibiotic premedication** for dental treatment?	Y	N
4.	Are you currently under a physician's care?	Y	N
	If so, what for? _____		
	_____		
	Treating Physician's Name: _____ Phone #: _____		
5.	Have you had any serious illness, operations, or hospitalizations?	Y	N
	If so, describe and give approximate dates: _____		
	_____		
	_____		
6.	Have you ever had intravenous sedation or general anesthesia?	Y	N
	Were there any adverse effects?	Y	N
7.	Do you generally tolerate dental treatment well?	Y	N
8.	DO YOU HAVE OR HAVE YOU EVER HAD:		
	A. Heart disease that was detected at birth?	Y	N
	B. Rheumatic fever or Rheumatic heart disease?	Y	N
	C. Cardiovascular disease (chest pain, heart trouble, heart attack, coronary artery disease, high blood pressure, stroke, palpatations, heart surgery, angioplasty, pacemaker)?	Y	N
	D. Lung Disease (asthma, emphysema, chronic cough, bronchitis, pneumonia, TB, shortness of breath, cough?	Y	N
	E. Neurologic Disorders (seizure, epilepsy, fainting, dizziness, nervous disorder)?	Y	N
	F. Blood Disease (bleeding disorder, anemia, blood transfusion, do you bruise easily)?	Y	N
	G. Liver Disease (jaundice, hepatitis)?	Y	N
	H. Kidney Disease?	Y	N
	I. Diabetes?	Y	N
	J. Thyroid Disease?	Y	N
	K. Arthritis?	Y	N
	L. Stomach ulcers or Intestinal problems?	Y	N
	M. Glaucoma?	Y	N
	N. Frequent or recurring mouth sores?	Y	N
	O. Implants;artificial joints anywhere in your body? (includes heart valve, hip, knee)	Y	N
	P. Radiation (X-Ray treatment for cancer) in head and neck region?	Y	N
	Q. Noises in jaw joint, pain near ear when chewing, do you grind or clench your teeth?	Y	N
	R. Sinus or nasal problems?	Y	N
	S. Any disease, drug or transplant operation that has depressed your immune system?	Y	N
	T. Recurrent infections of any kind?	Y	N
	U. Diagnosed low bone density? If so, have you ever taken any type of "**bisphosphonate**" medication?	Y	N
9.	ARE YOU TAKING OR USING ANY OF THE FOLLOWING:		
	A. Antibiotics?	Y	N
	B. Anticoagulants?	Y	N
	C. Thyroid medications?	Y	N
	D. Antihistamines, decongestants?	Y	N
	E. High blood pressure or heart?	Y	N
	F. Steroids?	Y	N
	G. Tranquilizers, Antidepressants?	Y	N
	H. Stomach or GI medications (antacids, etc.)?	Y	N
	I. Cholesterol reducing drugs?	Y	N
	J. Aspirin, ibuprofen, NSAIDS, or anti-inflammatory drugs, narcotics, opioids, or other pain relievers?	Y	N
	K. Weight reduction pills or diet aids (over the counter or natural products)?	Y	N

L.	Vitamins, Natural remedies (ginko biloba, ephedra, ginseng, etc.) or other supplements?	Y	N
M.	Marijuana, cocaine, or other recreational drugs (PLEASE BE HONEST)	Y	N
N.	Any other regular medications, pills, supplements or drugs?	Y	N

PLEASE LIST ALL CURRENT MEDICATIONS AND DOSAGES:_____

_____

_____

10.	ARE YOU ALLERGIC TO OR HAD A BAD REACTION FROM:			
	A.	Local anesthetic (Novocaine-like drugs)?	Y	N
	B.	Penicillin, Amoxicillin, Cephalosporins?	Y	N
	C.	Other antibiotics?	Y	N
	D.	Barbiturates, sedatives?	Y	N
	E.	Aspirin, ibuprofen, NSAIDS, or other pain medications?	Y	N
	F.	Codeine or other narcotics or opiods?	Y	N
	G.	Latex?	Y	N
	H.	Other allergies or reactions?	Y	N
		Please list:_____		
		_____		
11.		Do you have any fever, frequent skin rashes, etc.?	Y	N
12.		Do you use alcohol? How much per day?_____	Y	N
13.		Do you smoke?	Y	N
		What do you smoke and how many per day?_____ For how long?_____	Y	N
14.		Do you use smokeless tobacco?	Y	N
15.		Are you or have you been in a drug or alcohol recovery program?	Y	N
16.		Do you have any other disease, condition or problem not listed above that you think the doctor should know about?	Y	N

17. WOMEN

A.	Are you taking birth control pills?	Y	N
B.	Are you pregnant, trying to become pregnant or is there any chance that you might be pregnant?	Y	N
C.	Are you breast feeding?	Y	N
D.	Are you taking hormone replacements?	Y	N
E.	Have you ever taken any type of “bisphosphonate” medication for bone density?	Y	N

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.

_____ _____

Date **Signature of person completing this Health History**

THANK YOU. Please return this form to the receptionist.

Dr. George Holling D.D.S., M.S.
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