Patient Health Questionnaire

Patient's Name: ______________________ **Today's Date:** ______________

Date of Birth: ______________________ SSN: ______________

Please answer all questions by checking Yes or No

All answers are kept confidential

Medical History

Physician ______________ **Office Phone** ______________ **Date of Last Exam** ______________

	Yes	No
1. Are you presently under medical treatment?	☐	☐
2. Have you had any serious illnesses or surgery?	☐	☐
Please specify ______________		
3. Do you use tobacco?	☐	☐
If so, what form? ______________		
4. Do you use alcohol?	☐	☐
5. Do you use cocaine or other drugs?	☐	☐

6. Are you allergic to or have you had any adverse reactions to:	Yes	No
a) Local Anesthetics (ex. novocaine)	☐	☐
b) Penicillin	☐	☐
c) Aspirin	☐	☐
d) Latex or rubber	☐	☐
e) Other	☐	☐

7. List medicines you are taking: ______________

	Yes	No
a) Are you pregnant or nursing or think you may be pregnant?	☐	☐
b) Are you taking birth control pills or hormones?	☐	☐
c) Are you taking diet pills?	☐	☐

8. Do you have or have you ever had any of the following:

	Yes	No
a) Heart problems	☐	☐
b) Heart murmur	☐	☐
c) Mitral Valve Prolapse	☐	☐
d) Cardiac Pacemaker	☐	☐
e) Rheumatic Fever	☐	☐
f) High Blood Pressure	☐	☐
g) Stroke	☐	☐
h) Epilepsy	☐	☐
i) Diabetes	☐	☐
j) Lung Disease	☐	☐
k) Kidney Disease	☐	☐
l) Asthma	☐	☐
m) Thyroid problem	☐	☐
n) Tuberculosis	☐	☐
o) Liver Disease	☐	☐
p) Hepatitis	☐	☐
q) Glaucoma	☐	☐
r) AIDS/HIV	☐	☐
s) Venereal Disease	☐	☐
t) Stomach Problems/Ulcers	☐	☐
u) Cancer	☐	☐
v) Arthritis	☐	☐
w) Joint replacement or implant	☐	☐
x) Radiation/Therapy	☐	☐
y) Other	☐	☐

Dental History

	Yes	No
1. Do your gums bleed?	☐	☐
2. Are your teeth sensitive?	☐	☐
3. Do you have any tooth related pain?	☐	☐
4. Have you had any head, neck, or jaw injuries?	☐	☐
5. Do you have any jaw discomfort?	☐	☐
6. Do you have frequent headaches?	☐	☐
7. Do you clench or grind your teeth?	☐	☐
8. Do you bleed easily?	☐	☐
9. Have you had any orthodontic work?	☐	☐
10. Are you happy with the appearance of your teeth?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X ____

Signature of patient or parent if minor — Date

FORM 035121 N/09/10 ITEM 8101