HEALTH QUESTIONNAIRE

Birth	Date:	ST.	Date:			
Nam	ie:	Soc	c. Sec. No:			
	Last First	Middle				
Addr	ress:	Phone No.: Cell: _				
	Number and Stree	et				
	0:4	Do Do	you have Dental Insu	urance?		
		tate Zip	6			
Age:	Sex: H	Height:Occupation:				
Sing	osest Relative or Friend: Phone: Phone:					
Clos						
The	name and address of my phys	sician is:				
1110						
	e following questions, circle you				ly and will b	е
1.	Are you now under the care	of a physician			YES	NO
	If so, what is the condition being treated?					
2.	Are you taking any medicine	?			YES	NO
	If YES, list all medicines:					
3.	Have you had any serious il	Iness or operations?			YES	NO
4.	Are you allergic to penicillin or any drugs or medicine?				YES	NO
	If YES, list all medicines:					
5.	Have you ever had any excessive bleeding requiring special treatment?				YES	NO
6.	Do you have any blood disorders?					NO
7.	Circle any of the following which you have had:					
	heart trouble	asthma	arthritis	rheumatic fe	ovor.	
	high blood pressure	cough	stroke	anemia	evei	
	congenital heart diseases	diabetes	epilepsy	heart murm	ur	
	tuberculosis	psychiatric treatment	hepatitis	sinus trouble	е	
	fainting spells	hay fever				
8.	Do you have any diseases, condition or problems not listed above that you think I should kn				w about? YES	NO
	If so, please explain:				120	110
9.	(Women) Are you pregnant now?				YES	NO
10.	Are you taking birth control pills?				YES	NO
11.	Have you had any serious trouble with any previous dental treatment?				YES	NO
	If so, please explain					
12.	Are you currently using or ha	ave used Phen-fen or any	other diet medication	s?	YES	NO

Signature of Dentist

Signature of Patient (Parent if Minor)