Clermont Family Dentistry

Health Questionnaire

Name: ____ Date: ______________________

Address: ____ Apt/Unit: __________________

City ________________________________ State: ____________________Zip_______________

DOB: ______________ Home phone :______________________ Cell :_____________________

Email: ____

Social Security #: ________________________ Best method of contact: ☐ Home ☐ Mobile ☐ Email

☐ Male ☐ Female ☐ Additional Category (please specify): ___________________ ☐ Decline to Answer

☐ Married ☐ Spouse's Name: ____________________ ☐ Single ☐ Parents name: ________________

Responsible Party/Insurance Policy Holder Information

Name: ____

Social Security #: _______________________Date of Birth: ______________________________

Address: ____

Referral Information

Whom may we thank for referring you to our practice? ☐ Dental Office ☐ News Leader ☐ Google
☐ Insurance Network ☐ Facebook ☐ Another patient, friend/relative ☐ Other ___________________
Name of person or office referring you to our practice: _____________________________________

CIRCLE ANY OF THE FOLLOWING THAT YOU CURRENTLY HAVE OR HAVE HAD:

Date of last dental visit: _______________ Reason for today's visit: _________________________

AIDS or HIV
Allergies:
___Sulfa
___Latex
___Penicillin
___Codeine
Anemia
Arthritis
Artificial Joints/Pins
Asthma
Blood Disease
Blood Thinners
Cancer
Chemotherapy
Diabetes
Drug Addiction
Epilepsy

Emphysema
Excessive Bleeding
Glaucoma
Head Injuries
Heart Disease
Heart Murmur
Hepatitis: type____
Herpes Infection
Hemophilia
High/Low Blood Pressure
Jaundice
Kidney Disease
Liver Disease
Mental Health
Nervous Disorder
Pacemaker

Pregnancy
Due date: __________
Radiation Treatment
Respiratory Problems
Rheumatic Fever
Rheumatism
Sinus Problems
Stomach Problems
Stroke
Tuberculosis
Thyroid Disease
Tumors
Ulcers
Venereal Disease

Other: ________________
____

CONTINUE ON BACK

Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain:____

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

If yes, please explain: ____

Are you now under the care of a physician? ☐ Yes ☐ No

If yes, please explain :____

Name of Physician: ______________________________ Phone: ______________

Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain:____
Are you currently taking any medications? ☐ Yes ☐ No
If yes, please explain:____

Are you or have you ever taken medication for osteoporosis? ☐ Yes ☐ No
Do you take Aspirin, Motrin or Tylenol daily? ☐ Yes ☐ No
Do you premed with antibiotics for dental appointments? ☐ Yes ☐ No
Have you ever bled excessively after dental appointment? ☐ Yes ☐ No
Do you ever have pain in your chest upon exertion? ☐ Yes ☐ No
Has there been a change in your general health in the last year? ☐ Yes ☐ No
Do your ankles swell? ☐ Yes ☐ No
Do you have a nasal obstruction? ☐ Yes ☐ No
Have you had dental x-rays taken in the past year? ☐ Yes ☐ No
Have you had an injury/surgery to your jaw or face? ☐ Yes ☐ No
Have you ever fainted in the dental office? ☐ Yes ☐ No
Do you use alcohol? ☐ Yes ☐ No
How often? ______________
Do you use tobacco in any form? ☐ Yes ☐ No
☐ Chew ☐ Dip ☐ Cigarettes ☐ Cigars ☐ Pipe
Do you have a cold or respiratory infection now? ☐ Yes ☐ No
Have you ever had a reaction to dental anesthetic? ☐ Yes ☐ No

Woman:
Are you pregnant now? (if unsure please answer yes) ☐ Yes ☐ No
Are you taking Birth Control? ☐ Yes ☐ No
Do you anticipate becoming pregnant? ☐ Yes ☐ No
Are you a nursing mother? ☐ Yes ☐ No

How do you feel about your smile? ____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail. I will not hold my dentist or any member of his/her staff, responsible for any error or omissions that I may have made in the completion of the form.

Signature: ________________________________ Date: ______________
Signature of patient, parent or guardian

REVIEWED MEDICAL HISTORY BY DENTIST

SIGNATURE: ________________________