HEALTH QUESTIONNAIRE

1. How would you describe your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

2. Have you been under a physician's care or been hospitalized in the last 2 years? ☐ YES ☐ NO

   Physician's Name _____ Phone Number (_____) _____

   Physician's Name _____ Phone Number (_____) _____

   For what condition(s) are you being treated? _____

3. List all medications you are now taking (include vitamins, laxatives, birth control pills, etc.): _____

   _____

   _____

   _____

4. Are you allergic to (i.e. itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs/medications?

   (If so, please list) _____

5. Have you ever had any excessive bleeding requiring special treatment? ☐ YES ☐ NO

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

Heart Failure	Stroke	Chemotherapy (Cancer, Leukemia)	Drug Addiction
Heart Disease or Attack	Kidney Trouble	Arthritis	Hemophilia
Angina Pectoris (Chest Pain)	Ulcers	Rheumatism	Venereal Disease (Syphilis, Gonorrhea)
High Blood Pressure	Emphysema	Cortisone Medicine	Cold Sores
Heart Murmur	Cough	Glaucoma	Genital Herpes
Rheumatic Fever	Tuberculosis (TB)	Pain in Jaw Joints	Epilepsy or Seisures
Congenital Heart Lesions	Asthma	AIDS	Fainting or Dizzy Spells
Scarlet Fever	Hay Fever	Hepatitis A (infectious)	Nervousness
Artificial Heart Valve	Sinus Trouble	Hepatitis B (serum)	Psychiatric Treatment
Heart Pacemaker	Allergies or Hives	Bruise Easily	Sickle Cell Disease
Heart Surgery	Diabetes	Liver Disease	
Artificial Joint	Thyroid Disease	Yellow Jaundice	Other
Anemia	X-ray or Cobalt Treatment	Blood Transfusion	_____

7. Have you ever been tested for the HIV virus? ☐ YES ☐ NO Date _____ Result (circle one) + –

8. Do you have any disease, condition or problem not listed above? ☐ YES ☐ NO _____

9. (Women) Are you pregnant now? ☐ YES ☐ NO

10. Have you ever premedicated with antibiotic prior to dental work? ☐ YES ☐ NO

11. What was the date of your last dental exam? _____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medications change, I will inform Dr. Baumann at the next appointment without fail.

Date	Signature of Patient	Signature of Parent or Guardian

MEDICAL HISTORY UPDATE

DATE	ADDITION	DATE	ADDITION