HEALTH QUESTIONNAIRE

General Physician: _____Phone Number: (_____)_____-_____
Cardiologist: _____Phone Number: (_____)_____-_____
Date of Last Physical Exam: _____

In case of Emergency, please call:
Name: _____Phone Number: (_____)_____-_____
Relationship: _____

Please check any of the following that apply to you NOW or in the PAST:

- ❑ Angina
- ❑ Heart Attack
- ❑ Heart Problems
- ❑ Heart Murmur
- ❑ Heart Pacemaker
- ❑ Stroke
- ❑ Mitral Valve Prolapse
- ❑ Artificial Heart Valve
- ❑ Arrhythmia
- ❑ Stent (Heart)
- ❑ Artificial Joint
- ❑ Bisphosphonate Treatment (e.g.: Fosamax)
- ❑ Jaw Joint Pain (TMJD)
- ❑ Epilepsy
- ❑ Seizures
- ❑ Dizzy Spells / Fainting
- ❑ Arthritis
- ❑ Back / Neck Pain
- ❑ Chemotherapy
- ❑ Radiation Treatment
- ❑ Neurological Disorder
- ❑ Anxiety Disorder
- ❑ Dental Phobia
- ❑ Anemia
- ❑ Blood Transfusion
- ❑ Blood Disease
- ❑ Bleeding Problems
- ❑ High Blood Pressure
- ❑ Phen-Fen use
- ❑ Asthma
- ❑ Tuberculosis
- ❑ Smoking / Tobacco use
- ❑ Sinusitis / Hay Fever
- ❑ Thyroid Disease
- ❑ Liver Disease
- ❑ Kidney Disease
- ❑ Infectious Disease
- ❑ Hepatitis A / B / C
- ❑ Venereal Disease
- ❑ AIDS / HIV +
- ❑ Yellow Jaundice
- ❑ Drug Addiction
- ❑ Ulcers
- ❑ Colitis
- ❑ Diabetes Type I / II
- ❑ Sleep Apnea

Have you ever had an allergy or reaction to any of the following?:

- ❑ Penicillin
- ❑ Aspirin
- ❑ Codeine
- ❑ Cloves
- ❑ Bleach
- ❑ Ibuprofen
- ❑ Latex Rubber
- ❑ Chlorhexidine
- ❑ Local Anesthetics or Novocain
- ❑ Any Dental Materials _____
- ❑ Any Medications _____
- ❑ Other _____

❑ Any other disease or serious illness?: _____

Current Medications (including vitamins / herbs)? _____
_____
_____

Women – Are you: ❑ Taking Birth Control Pills ❑ Nursing

❑ Pregnant – How Many Weeks? _____
OBGYN Name: _____Phone Number: (_____)_____-_____

Signature: _____ Date: _____