# NORTH TEXAS PERIODONTAL SPECIALISTS

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*PERIODONTICS & DENTAL IMPLANTS*

## HEALTH QUESTIONNAIRE

PATIENT NAME ______________________________ SIGNATURE ______________________________ DATE ________

YOUR AGE ______ HEIGHT _________ WEIGHT __________ MO/YEAR OF YOUR LAST MEDICAL EXAMINATION ________________

PHYSICIAN NAME ______________________________

PHYSICIAN ADDRESS ____________________________ CITY __________________ PHONE ____________________

| YES | NO | ??? | |
|---|---|---|---|
| ☐ | ☐ | ☐ | HAS THERE BEEN ANY CHANGE IN YOUR GENERAL HEALTH IN THE PAST YEAR? |
| ☐ | ☐ | ☐ | HAVE YOU HAD A SERIOUS ILLNESS, OPERATION OR HOSPITALIZATION DURING THE PAST FIVE YEARS? IF YES, PLEASE DESCRIBE ______________________ |
| | | | PLEASE LIST ANY CURRENT MEDICATIONS : ______________________________ |
| ☐ | ☐ | ☐ | ARE YOU ALLERGIC TO ANY MEDICATIONS, DRUGS, LATEX IODINE? ______________________ |
| | | | HAVE YOU EVER<br>☐ RECEIVED I.V BISPHOSPHONATES? (AREDIA, ZOMETA)<br>☐ TAKEN ORALLY: ANY OTHER BISPHOSPHONATES ? (FOSAMAX, ACTONEL) |
| ☐ | ☐ | ☐ | HAVE YOU EVER TAKEN PONDIMIN (FENDLURAMINE) , PHEN-FEN (PHENTERMINE) OR REDUX (DEXPHENFLURAMINE) FOR WEIGHT REDUCTION? |
| ☐ | ☐ | ☐ | HAS YOUR M.D. TOLD YOU TO TAKE ANTIBIOTICS PRIOR TO HAVING ANY TYPE OF DENTAL PROCEDURE? |
| ☐ | ☐ | ☐ | HAVE YOU EVER HAD EXCESSIVE BLEEDING THAT REQUIRED SPECIAL TREATMENT? |
| ☐ | ☐ | ☐ | HAVE YOU BEEN DIAGNOSED AS HAVING ANY IMMUNODEFICIENCY, SYSTEMIC LUPUS, ARC OR AIDS? |
| ☐ | ☐ | ☐ | IS THERE A HISTORY OF DIABETES IN YOUR FAMILY? |
| ☐ | ☐ | ☐ | ARE YOU REQUIRED, DUE TO HEALTH, TO RESTRICT YOUR WORK OR ACTIVITY IN ANY WAY? |
| ☐ | ☐ | ☐ | ARE YOU ON A SPECIAL OR RESTRICTED DIET OF ANY KIND? ____________________ |
| ☐ | ☐ | ☐ | DO YOU USE ANY KIND OF TOBACCO? IF SO HOW MUCH: ________ PER DAY, WEEK, MONTH |
| ☐ | ☐ | ☐ | DO YOU USE ANY KIND OF ALCOHOL? IF SO HOW MUCH: ________ PER DAY, WEEK, MONTH |
| ☐ | ☐ | ☐ | DO YOU HAVE ANY HISTORY OF SUBSTANCE ABUSE OR DO YOU CURRENTLY USE RECREATIONAL DRUGS? |

FOR WOMEN, CHECK ALL THAT ARE APPROPRIATE: ☐ I AM PREGNANT ☐ I AM NURSING ☐ I AM TAKING BIRTH CONTROL PILLS

CHECK ALL OF THE FOLLOWING THAT YOU MAY HAVE HAD IN THE PAST OR THAT CURRENTLY APPLY TO YOU:

| | | | |
|---|---|---|---|
| ☐ CHEST PAIN UPON EXERTION | ☐ RECEIVED BLOOD TRANSFUSION | ☐ SLEEP APNEA | ☐ HEADACHES |
| ☐ SHORTNESS OF BREATH | ☐ IMPAIRED LIVER FUNCTION | ☐ ASTHMA | ☐ MIGRAINES |
| ☐ HIGH BLOOD PRESSURE | ☐ KIDNEY DISEASE | ☐ BRONCHITIS | ☐ EPILEPSY |
| ☐ LOW BLOOD PRESSURE | ☐ IMPAIRED KIDNEY FUNCTION | ☐ EMPHYSEMA | ☐ SEIZURES |
| ☐ HEART VALVE PROSTHESIS | ☐ ESOPHYGEAL REFLUX | ☐ SINUS TROUBLES | ☐ G.I. ULCERS |
| ☐ MENTAL HEALTH PROBLEMS | ☐ MITRAL VALVE PROLAPSE | ☐ HIATAL HERNIA | ☐ GLAUCOMA |
| ☐ PERSISTENT COUGH | ☐ RECURRENT INFECTIONS | ☐ RHEUMATIC FEVER | ☐ COLITIS |
| ☐ CONGENITAL HEART LESION | ☐ JOINT REPLACEMENT SURGERY | ☐ WEAR CONTACT LENSES | ☐ ARTHRITIS |
| ☐ ANOREXIA OR BULEMIA | ☐ SEVERELY IMPAIRED VISION | ☐ DAMAGED HEART VALVE | ☐ DIABETES |
| ☐ HEART MURMUR | ☐ IRRITABLE BOWEL SYNDROME | ☐ TACHYCARDIA | ☐ STROKE |
| ☐ HEART ARRTHYMIA | ☐ RECENT WEIGHT LOSS | ☐ TUBERCULOSIS | |
| ☐ CONNECTIVE TISSUE DISORDER | ☐ OSTEOPOROSIS | ☐ CHRONIC FATIGUE | |
| ☐ HEART SURGERY | ☐ RADIATION THERAPY | ☐ HISTORY OF CANCER | |
| ☐ CARDIAC PACEMAKER | ☐ CHEMOTHERAPY | ☐ NEUROLOGICAL DISORDERS | |
| ☐ HEPATITIS OR JAUNDICE | | | |

**REVIEWED BY** ______________________________ **DATE** ____________