

NORTHEAST TEXAS PERIODONTAL SPECIALISTS

Periodontics & Dental Implants

HEALTH QUESTIONNAIRE

Patient name _____ Signature _____ Date _____

Your Age _____ Height _____ Weight _____ Month/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 including over-the-counter:** _____
- Are you Allergic to any medications, drugs, latex, or iodine? _____
- Have you ever Received I.V. Bisphosphonates? (Aredia, Zometa)
Or 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? If yes, please describe: _____
- 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:

- | | | | |
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| <input type="checkbox"/> Chest Pain Upon Exertion | <input type="checkbox"/> Stroke | <input type="checkbox"/> Asthma | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> Shortness Of Breath | <input type="checkbox"/> Mental Health Problems | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Joint Replacement Surge |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Impaired Kidney Function | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Seizures | <input type="checkbox"/> Esophageal Reflux | <input type="checkbox"/> Anorexia Or Bulimia |
| <input type="checkbox"/> Heart Valve Prosthesis | <input type="checkbox"/> Migraines | <input type="checkbox"/> Sinus Troubles | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Congenital Heart Lesion | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> GI Ulcers | <input type="checkbox"/> Connective Tissue Disorder |
| <input type="checkbox"/> Cardiac Pacemaker | <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Hepatitis Or Jaundice |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Recent Weight Loss |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Tachycardia | <input type="checkbox"/> Received Blood Transfusion | <input type="checkbox"/> Wear Contact Lenses | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Severely Impaired Vision | <input type="checkbox"/> History Of Cancer |
| <input type="checkbox"/> Heart Arrhythmia | <input type="checkbox"/> Headaches | <input type="checkbox"/> Recurrent Infections | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Damaged Heart Valve | <input type="checkbox"/> Impaired Liver Function | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Radiation Therapy |

For office use only:

Reviewed by _____ Date _____