# 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 _____ |
| ☐ | ☐ | ☐ | **Currently taking any over-the-counter medications? Please list**: _____ |
| ☐ | ☐ | ☐ | 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:

| | | | |
|---|---|---|---|
| ☐ 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 | ☐ Esophageal Reflux | ☐ Sinus Troubles | ☐ GI 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 Bulimia | ☐ Severely Impaired Vision | ☐ Damaged Heart Valve | ☐ Diabetes |
| ☐ Heart Murmur | ☐ Irritable Bowel Syndrome | ☐ Tachycardia | ☐ Stroke |
| ☐ Heart Arrhythmia | ☐ Recent Weight Loss | ☐ Hepatitis Or Jaundice | ☐ Tuberculosis |
| ☐ Chronic Fatigue | ☐ Connective Tissue Disorder | ☐ Osteoporosis | ☐ Heart Surgery |
| ☐ Radiation Therapy | ☐ History Of Cancer | ☐ Cardiac Pacemaker | ☐ Chemotherapy |

**For office use only:**

Reviewed by_____ Date_____