HEALTH QUESTIONNAIRE *(Please check your answers)*

*Patient's Name*______________________________ *Date*____________________

*Pharmacy*______________________________

Location (cross streets) ______________________________

*Medical Doctor's Name*______________________________ *Telephone Number* ____________________

Medical Doctor's Address ______________________________

*Date of last physical exam*__________ *Last visit*__________ *Why?*____________________

Are you presently under the care of a Medical Doctor ☐ *yes* ☐ *no*

If yes, why? ______________________________

Have you had any major illness, operation, or hospitalization? ☐ *yes* ☐ *no*

Please list ______________________________

Are you taking any medications ☐ *yes* ☐ *no* *If yes, list medications, doses, and frequency* ____________________

____

Do you take vitamin or herbal supplements? ☐ *yes* ☐ *no* *Please list* ____________________

Have you taken antibiotics within the last six months for any reason? ☐ *yes* ☐ *no*

Do you take aspirin on a daily basis? ☐ *yes* ☐ *no*

Are you allergic or have reacted adversely to local anesthetic, penicillin, codeine or any other drug or medications ☐ *yes* ☐ *no*

Please list any allergies ______________________________

Have you ever been addicted to drugs or alcohol? ☐ *yes* ☐ *no*

Have you ever had treatment for drug or alcohol problems? ☐ *yes* ☐ *no*

Present weight __________

Have you had any of the following? *(Please check your answers)*

	Yes	*No*
Heart disease or heart surgery	☐	☐
Heart attack	☐	☐
Pain in chest	☐	☐
Rheumatic fever	☐	☐
Heart murmur/ mitral valve prolapse	☐	☐
Have you ever had an echocardiogram?	☐	☐
Do you have any type of artificial heart valve or joint now in place?	☐	☐
High blood pressure (usual________)	☐	☐
Stroke	☐	☐
Excessive bleeding	☐	☐
Lung disease	☐	☐
Tuberculosis (TB)	☐	☐
Asthma/ emphysema	☐	☐
Do you smoke?	☐	☐

If so, how many packs per day? ______

How many years? _______

	Yes	*No*
Glaucoma	☐	☐
Epilepsy	☐	☐
Hepatitis, jaundice or liver disease	☐	☐
Stomach ulcer	☐	☐
Kidney problems	☐	☐
Thyroid problems	☐	☐
Arthritis	☐	☐
Osteoporosis	☐	☐
Sinus problems	☐	☐
Cancer or radiation therapy	☐	☐
Sexually transmitted diseases	☐	☐
HIV positive, AIDS	☐	☐
Diabetes	☐	☐
Has any member of your family had diabetes?	☐	☐

(WOMEN)	*yes*	*no*
1. Is there any chance you may be pregnant now?	☐	☐
2. Hysterectomy?	☐	☐
3. Are you taking birth control pills?	☐	☐
4. Are you nursing?	☐	☐

Do you have any disease, condition or problem not listed you think we should know about that you believe would affect treatment in any way? ______________________________

____

(Over)

DENTAL QUESTIONNAIRE - Page two

Name ______________________________

Your reasons for making this appointment ______________________________
Date of last dental examination ______________________________
Date of last prophy (teeth cleaning) ____________________ *By whom?* ____________
Do you have additional appointments scheduled with your restorative dentist? *Yes* ☐ *No* ☐
If yes, when and for what purpose? ______________________________
Previous major dental treatment. Please give dates and explain ______________________________
____
____
In your opinion, what is your general dental condition? ______________________________

Have you had? (Please check your answers)

	Yes	No
Recent pain in mouth or face	☐	☐
Bleeding gums	☐	☐
Loose teeth	☐	☐
Bad breath	☐	☐
Unpleasant taste	☐	☐
Food impaction	☐	☐
Swelling or lumps in mouth	☐	☐
Teeth sensitive to hot, cold, sweet	☐	☐
Clenching or grinding of teeth	☐	☐

	Yes	No
Periodontic (gum) treatment	☐	☐
Orthodontic (braces) treatment	☐	☐
Mouth breathing	☐	☐
Injury to face or jaws	☐	☐
Popping, clicking or soreness in the joints in front of ears	☐	☐
Pain around ears	☐	☐
Do you awake with a sore jaw?	☐	☐

	Yes	No
Are you chewing satisfactorily?	☐	☐
Are you satisfied with the appearance of your teeth?	☐	☐

If not satisfied with your appearance and chewing, what would you wish to change? ______________________________
____
How frequently have you had your teeth cleaned? ______________________________
How often do you brush your teeth? ______________________________
Do you use dental floss? ☐ *yes* ☐ *no* *How often?* ______________________________
How do you feel about keeping your teeth? ______________________________
Are you apprehensive about dental treatment? ☐ *yes* ☐ *no* *If so, for what reason?* ______________________________
____

CONSENT:
I hereby certify that I have told Dr. Woody and/or staff, the full truth about my medical and dental condition to the best of my ability.
I authorize Dr.Woody and staff to take X-rays, photographs, or any other diagnostic aids deemed appropriate by Dr. Woody and staff to make a thorough diagnosis of my dental needs. I also understand the use of local anesthetic agents embodies a certain risk.

Patient's Signature ____________________ ***Date*** ________ ***Witness*** ____________
(Or parent if minor)

Reviewed By: ______________________________

Thank you for taking the time to provide this information.

5989 E. Colfax Ave. • Denver, CO 80220 • (O) 303.388.9000 • (F) 303.322.3521

info@woodydentaldenver.com • www.woodydentaldenver.com