CONFIDENTIAL HEALTH QUESTIONNAIRE

Name ______________________ Home Phone ______________________

Address ______________________ Work Phone ______________________

City __________ State __________ Zip __________ Message Phone ______________________

Date of Birth ______________________ Male ☐ Female ☐

Reason for today's visit? In Pain ☐ Join Practice ☐

Place of Employment ______________________

Insurance ______________________

SS# ______________________

Physician Name ______________________

Physician Address ______________________ Date of Last Visit ______________________

Are you aware of any particular dental problems? ______________________

Are you having any discomfort or pain? ______________________

How long has it been since you last visited a dental office? ______________________

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS?:

Has there been any problem in your general health within the past 5 years? (serious illness; hospitalization; surgery; etc.) Yes ☐ No ☐

If so, what was the problem? ______________________

Have you had any form of Cancer? Yes ☐ No ☐ If so, what type or name? ______________________

Date of last medical check-up? ______________________ Attending Physician ______________________

Date of last blood test? ______________________ Attending Physician ______________________

Are you under a physician's care now? Yes ☐ No ☐ If so, for what? ______________________

What tablets, pills, or liquids do you take? (this includes aspirin, vitamins, tonics, etc.) ______________________

Does your physician require you to take special medication before dentistry? Yes ☐ No ☐ If so, what? ______________________

	YES	NO			YES	NO
Rheumatic fever, rheumatic heart disease			Persistent cough, coughing up blood			
Heart trouble, heart attack, high blood pressure, stroke			Diabetes			
Heart murmur, Mitral Valve Prolapse			Radiation treatment for a tumor or other growth			
Blood disorders, anemia			Blood thinners or aspirin daily			
Pain in chest, shortness of breath, swollen ankles			Sores that did not heal within one week			
Cold sores or herpes incident			Are you pregnant?			
Positive test for venereal disease within five years			Are you sensitive or allergic to:	Penicillin		
Are you positive for HIV / AIDS virus?				Codeine		
Abnormal bleeding, prolonged healing, bruises easily				Novocaine		
Asthma, hay fevers				Aspirin		
Low blood pressure				Latex		
Fainting spells, seizures			Other anesthetics			
Hepatitis, jaundice, liver diseases			Other drugs			
Arthritis			Past or present drug addictions			
Have you had an orthopedic joint replacement?			Past or present alcoholic problems			
Have you had an organ transplant?			Do you smoke?			
Kidney troubles			Do you have any disease, condition, or problem not listed			
Tuberculosis, other lung ailments			above that you think the doctor should know about?			
Any physical or mental handicaps?						

Signature ______________________ Date ______________________

Form BMP #5393 Rev. 12-2013 LDC

THANK YOU FOR YOUR COOPERATION !!! ● WELCOME TO LOCUST DENTAL CENTER