Jay K. Selznick, D.M.D., M.D.

Health Questionnaire

___/____/____ ___________________________________ ___/___/____

Date **Patient Name** **Birthdate**

Name of person completing form (**if different from patient**): ___________________________________

*Please answer all questions to the best of your ability, realizing that true and accurate answers are important to the delivery of quality care. **All information you provide will be kept confidential.**

1. Are you in good health? ____ Y / N
2. Has there been any change in your general health in the past year? ___________________ Y / N
3. Date of last check up by physician:____
4. Are you currently under a physician's care? Y / N
   If so, what for? ____
5. Name of physician:_____________________ Phone #:________________________________
6. Have you had any serious illness, operations, or hospitalizations? Y / N
   If so, please describe and give approximate dates: ___________________________________
   ____
   ____
7. Have you ever had intravenous sedation or general anesthesia? Y / N
   Where there any adverse effects? ____ Y / N
8. Do you generally tolerate dental treatment well? Y / N
9. Do you have or have you ever had:
   - **A. Heart disease that was detected at birth?**_______________________________ Y / N
   - **B. Rheumatic fever or rheumatic heart disease?** _____________________________ Y / N
   - **C. Cardiovascular disease (chest pain, heart trouble, heart attack, coronary artery disease, high blood pressure, stroke, palpitations, heart surgery, angioplasty, pacemaker)?** Y / N
   - **D. Lung disease (asthma, emphysema, chronic cough, bronchitis, pneumonia, TB, shortness of breath)?** ____ Y / N
   - **E. Neurologic disorder (seizure, epilepsy, fainting, dizziness, nervous disorder)?** Y / N
   - **F. Blood disease (bleeding disorder, anemia, blood transfusion, bruise easily)?** Y / N
   - **G. Liver disease (jaundice, hepatitis)?** _______________________________________ Y / N
   - **H. Kidney disease?** ____ Y / N
   - **I. Diabetes?** ____ Y / N
   - **J. Thyroid disease (hypothyroidism, tumor)?** ________________________________ Y / N
   - **K. Arthritis? If so, where?** ____ Y / N
   - **L. Stomach ulcers or intestinal problems?** __________________________________ Y / N
   - **M. Glaucoma?** ____ Y / N
   - **N. Frequent or recurring mouth sores?** _____________________________________ Y / N
   - **O. Implants or artificial joints anywhere in your body (heart, hip, knee)?** ____________________ Y / N
   - **P. Radiation treatment anywhere in head or neck region?** ____________________ Y / N
   - **Q. Noises in jaw joint, pain near ear when chewing?** _________________________ Y / N
   - **R. Do you grind or clench your teeth?** ______________________________________ Y / N
   - **S. Sinus or nasal problems?** ____ Y / N

T. **Any disease, drug, or transplant operation that depressed your immune system?** ___________________________________ Y / N

U. **Recurrent infections of any kind?** ______________________________________ Y / N

10. Are you taking any of the following:

A. **Antibiotics?** ____ Y / N
B. **Anticoagulants?** _______________________________________ Y / N
C. **Thyroid medication?** ____________________________________ Y / N
D. **Antihistamines, decongestants?** ___________________________ Y / N
E. **High blood pressure medication?** __________________________ Y / N
F. **Steroids?** ____ Y / N
G. **Tranquilizers, antidepressants?** ____________________________ Y / N
H. **Stomach or GI medications (antacids, etc.)?** _________________ Y / N
I. **Cholesterol reducing drugs?** _______________________________
J. **Aspirin, ibuprofen, NSAIDS, anti-inflammatory drugs, narcotics, opioids, or other pain relievers?** ____________________________ Y / N
K. **Weight reduction pills or diet aids (over the counter or "natural" products)?** __________________ Y / N
L. **Vitamins, natural remedies, or other supplements?** ____________ Y / N
M. **Marijuana, cocaine, or other recreational drugs?** ______________ Y / N
N. **Any other regular medications, pills, supplements, or drugs?** ____ Y / N

Please List ALL medications here

____

____

____

11. Are you allergic to or had a bad reaction from:

A. **Local anesthetic (Novocaine, Lidocaine, etc.)?** ____________________________________ Y / N
B. **Penicillin, Amoxicillin, Cephalosporin?** ____ Y / N
C. **Other antibiotics?** ____ Y / N
D. **Barbiturates, sedatives?** ____ Y / N
E. **Aspirin, ibuprofen, NSAIDS, or other pain medications?** ____________________________ Y / N
F. **Codeine or other narcotics or opioids?** ____ Y / N
G. **Latex?** ____ Y / N
H. **Other allergies or reactions?** Y / N
Please list ____

12. Do you have hay fever, frequent skin rashes, etc.? ____ Y / N

13. Do you consume alcohol? ____ Y / N

14. Do you smoke or use tobacco? _Y / N__ How much per day? __________ For how long? ________

15. Are you, or have you ever been, in a drug or alcohol recovery program _________________________ Y / N

16. Do you have any other disease or condition that is not listed that the doctor should know about? Y / N

17. Do you wish to talk to the doctor privately about anything?____________________________________ Y / N

18. Any additional comments?____ Y / N

Women

1. Are you currently taking birth control?____ Y / N
2. Are you pregnant, trying to become pregnant, or are there any chances that you might be pregnant? ____ Y / N
3. Are you currently breast feeding? ____ Y / N
4. Are you taking hormonal replacement? ____ Y / N

---

*I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of knowledge, the information provided above is complete and accurate.

Signature: _________________________________ **Date**: _________________ **Doctor's initials**: ______________

Medical Update

I have reviewed my health history dated__________ and confirm that it accurately states past and present conditions.

*__Exceptions__:____

____

____

____

____

Signature of person completing update: _________________________________

Relationship to patient: ______________________ **Date**: ___________________ **Doctor's Initials**: _____________