Milwaukee DENTAL ARTS

HEALTH QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____

Chief Complaint (Why are you seeking dental care?) _____

Current State of Health

Are you in good health? Yes _____ No _____

Are you currently under the care of a physician? Yes _____ No _____

Please list your family physician and any medical specialist you see at least once a year: (Please print)

Name	Address	City	Phone #	Specialty

Medical History

Circle below:

1. Do you have (or have you ever had) any of the following?

Yes No a. Allergic reaction to drugs or latex? (circle all that apply)
Latex Penicillin Aspirin Codeine Local Anesthetics Other _____

Yes No b. Heart attack or heart disease

Yes No c. Stroke

Yes No d. High blood pressure _____ Low blood pressure _____

Yes No e. Congestive heart failure

Yes No f. Angina (chest pain)

Yes No g. Irregular heart beat

Yes No h. Artificial heart valve

Yes No i. Bacterial endocarditis, Rheumatic fever, Rheumatic heart disease

Yes No j. Congenital heart disease

Yes No k. Heart murmur or Mitral valve prolapse

Yes No l. Immunosuppressive condition (circle all that apply)
Steroid Therapy (e.g. prednisone) Rheumatoid Arthritis HIV Radiation or Cancer Therapy
SLE (Lupus) Organ Transplant Spleen removed Other _____

Yes No m. Artificial joint(s) (circle all that apply)

	Hip	Ankle	Knee	Shoulder
Date(s) placed:	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Yes No n. Other artificial implants or devices, i.e. pacemaker

Yes No o. Bleeding problem, Anemia, other blood disease

Yes No p. Diabetes Type I _____ Type II _____

Yes No q. Thyroid disease
Yes No r. Long term antibiotic use (greater than one month continuously) _____
Yes No s. Nervous system disease or seizures
Yes No t. Kidney disease
Yes No u. Hepatitis (A, B, C or D) or other Liver disease
Yes No v. Muscle or joint disease or arthritis (osteo or rheumatoid)
Yes No w. Asthma, tuberculosis or other lung disease
Yes No x. Stomach or intestinal disease
Yes No y. Mental health condition - Please specify _____
Yes No z. Physical or mental disabilities that may require special care? _____
Yes No aa. Impairment of hearing, sight or speech
Yes No bb. Do you have or have you ever been treated for cancer? Type: _____

2. Are you or could you be pregnant?

Yes No

3. Are you nursing?

Yes No

4. Do you have any disease, condition, or problem not listed here?

Yes No Describe: _____

5. Have you ever been hospitalized or had surgery?

Yes No Describe: _____

6. Do you have any undiagnosed symptoms?

Yes No Describe: _____

7. Are you, or have you ever been addicted to a chemical substance?

Yes No Examples: alcohol, prescription drugs, heroin, methamphetamine, cocaine, other

8. Do you currently drink alcohol or use recreational drugs?

Yes No Describe: _____

9. Do you smoke or use smokeless tobacco?

Yes No

10. What type of tobacco product(s) do you use? _____

11. Do you regularly take herbal medicines or dietary supplements? Specifically, do you take, (circle all that apply)

Echinacea Garlic GingerKava Valerian Fish Oil Feverfew
Gingko Ginseng St. John's Wort Vitamin E Diet or Energy Supplements

12. Have you undergone current or past osteoporosis therapy?

Yes No Bisphosphonate Therapy? Examples: Fosamax, Actonel, Boniva pill form

13. Have you undergone current or past therapy to reduce high blood calcium?

Yes No Bisphosphonate Therapy? Examples: intravenous (IV) Aredia and/or Zometa

Dental History

14. Do you have regular dental check-ups?

Yes No Date of last exam: _____

15. Have you ever had any trouble associated with previous dental treatment?

Yes No If so, please explain: _____

16. Have you noticed any lumps or sores in your mouth?

Yes No _____

17. Do your gums bleed when you brush your teeth?

Yes No _____

18. Have you ever injured your face, jaw or teeth?

Yes No _____

19. Do you suffer from pain in the mouth, face, eyes, neck or throat?

Yes No _____

20. Has fear ever prevented you from seeking dental treatment?

Yes No _____

21. Are you allergic to any metal or dental materials?

Yes No _____

22. Circle the types of dental treatment you might be interested in:

Orthodontics (braces) Dentures Partials Implants Crowns Bridge

23. Are you happy with the appearance of your smile?

Yes No

24. If you could change your smile, would you (please check all that apply):

- ☐ Make your teeth whiter
- ☐ Make your teeth straighter
- ☐ Repair missing teeth
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover
- ☐ Close spaces between teeth
- ☐ Replace black metal fillings
- ☐ Repair chipped teeth

Please list the medications you are currently taking and then sign below:

Medication	Amount	Medication	Amount

Milwaukee Dental Arts requests this information for the purpose of providing a complete and comprehensive evaluation of your dental needs. No persons outside **Milwaukee Dental Arts** will be provided this information unless properly authorized by you or required by law. Failure to pro-vide the requested information will limit our ability to assess your needs and may result in us being unable to accept you as a patient. By signing below, you agree that the information given is accurate and that you will notify **Milwaukee Dental Arts** at subsequent appointments if there are any changes in your health.

Patient signature: _____ Date: _____

(Or) Patient's representative: _____ Relationship to patient: _____

Dentist's Signature: _____ Date: _____