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Lincoln Avenue Dental Group

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) Radiation or Cancer Therapy SLE (Lupus)

Rheumatoid Arthritis HIV Organ Transplant Spleen removed Other_____

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

Hip Ankle Shoulder Knee

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: _____

Yes No **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?**_____

Describe: _____

Yes No **5. Have you ever been hospitalized or had surgery**?_____

Describe: _____

Yes No **6. Do you have any undiagnosed symptoms?**_____

Describe: _____

Yes No **7. Are you, or have you ever been addicted to a chemical substance?**_____

examples: alcohol, prescription drugs, heroin, methamphetamine, cocaine, other_____

Yes No **8. Do you currently drink alcohol_____or use recreational drugs?_____**
Yes No **9. Do you smoke or use smokeless tobacco?**
Yes No **10. What type of tobacco product (s) do you use?** _____
Yes No **11. Do you regularly take herbal medicines or dietary supplements?**

Specifically, do you take, (circle all that apply)

Echinacea Garlic Ginger Kava Valerian Fish Oil Feverfew

Gingko Ginseng St. John's Wort Vitamin E Diet or Energy Supplements

Yes No **12. Have you undergone current or past osteoporosis therapy?**

Bisphosphonate Therapy?_____ Examples: Fosamax, Actonel, Boniva pill form

Yes No **13. Have you undergone current or past therapy to reduce high blood calcium?**

Bisphosphonate Therapy?_____ Examples: intravenous (IV) Aredia and/or Zometa

Dental History

Yes No **14. Do you have regular dental check –ups? Date of last exam:** _____

Yes No **15. Have you ever had any trouble associated with previous dental treatment?**

If so, please explain: _____

_____

Yes No **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

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

Medication	Amount	Medication	Amount

Lincoln Avenue Dental Group requests this information for the purpose of providing a complete and comprehensive evaluation of your dental needs. No persons outside Lincoln Avenue Dental Group will be provided this information unless properly authorized by you or required by law. Failure to provide 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 Lincoln Avenue Dental Group 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: _____