Mitch Marcus D.M.D., P.A.

Health Questionnaire

Name: ____
Address: ____
City: __________________________________ State: ____________________
Zip Code: ________________Home Phone: ( ) ______________________Cell Phone___________
Occupation: ________________ Work Phone: ( ) ______________ E-mail: ________________________
SS No.: ___________________________ Date of Birth: ______________________________
Person to contact in case of emergency: _____________________________________
Relationship to patient: ______________________Daytime phone number: ( ) ____________________
Medical Doctor's Name: ____
Address: ____
Date of last visit: ____

Your major dental problem or reason for seeking treatment is: _________________
____

ANSWER ALL QUESTIONS BY CIRCLING "YES" OR "NO" AND FILL IN ALL BLANK SPACES WHEN INDICATED.COMPLETE BOTH SIDES.

1. No Yes…..Have there been any changes in your general health within the past year?
2. No Yes…..Are you now under the care of a physician? If yes what is the condition being treated? ____
3. No Yes…..Have you been hospitalized or had a serious illness during the past 5 years? If yes what was the problem? ____

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING?

4. No Yes…..Rheumatic fever or rheumatic heart disease?
5. No Yes…..Heart murmur or congenital heart disease?
6. No Yes…..Heart trouble, heart attack, stroke, pacemaker, prosthetic (artificial) heart valve or heart surgery?
7. No Yes…..Shortness of breath or chest pain after mild exercise?
8. No Yes…..Do you use more than 2 pillows to sleep?
9. No Yes…..High blood pressure?
10. No Yes…..Do your ankles swell?
11. No Yes…..Asthma, emphysema or difficulty in breathing?
12. No Yes…..Seizures, convulsions or seizure disorder?
13. No Yes…..Diabetes?
14. No Yes…..A loss or gain of 10 lbs. or more in the past year?
15 No Yes…..Frequent urination (pass water more than 6 times a day)?
16. No Yes…..Excessive thirst, increase or decrease in appetite?
17. No Yes…..Hepatitis, jaundice, cirrhosis or liver disease?
18. No Yes…..AIDS or positive antibody test to HIV?
19. No Yes…..Arthritis?
20. No Yes…..Cancer, chemotherapy or radiation therapy?
21. No Yes…..Stomach or intestinal problems, ulcers, gastritis, colitis or frequent diarrhea?
22. No Yes…..Kidney trouble or renal dialysis?
23. No Yes…..Tuberculosis?
24. No Yes…...A persistent cough, sore throat or coughing up blood?
25. No Yes…..Venereal disease, gonorrhea, syphilis, or any other sexually transmitted disease?
26. No Yes…..Psychiatric therapy?
27. No Yes…..Thyroid disease?
28. No Yes…..Any artificial bones or joints implanted?
29. No Yes…..Any blood disorders such as anemia or sickle cell disease?
30. No Yes…..Frequent infections, fevers, skin rashes, swollen lymph nodes or fatigue?
31. No Yes…..Do you bleed excessively after you are cut?
32. No Yes…..Have you ever required blood transfusion?
33. No Yes…..Have you ever been denied permission to give blood?
34. No Yes…..Have you ever been in contact with any individual having hepatitis, tuberculosis or AIDS?
35 No Yes…..Do you use, are you addicted or recovering from drugs or alcohol?

DO YOU TAKE OR HAVE YOU TAKEN ANY OF THE FOLLOWING DRUGS OR MEDICATION IN THE PAST 6 MONTHS?

36. No Yes…..Anticoagulants (blood thinners)?
37. No Yes…..Medicine for high blood pressure or water pills?
38. No Yes…..Cortisone (steroids)?
39. No Yes…..Valium, Librium or tranquilizers?
40. No Yes…..Aspirin?
41. No Yes…..Insulin or pills for diabetes?
42. No Yes…..Digitalis or drugs for heart trouble?
43. No Yes…..Nitroglycerin or other medicine for angina pectoris (chest or heart pain)?
44. No Yes…..Birth control pills?
45. No Yes…...Dilantin?
46. No Yes…..Medicine not prescribed by a doctor?

Other____

ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION (such as: itching, rash, swelling of hands, feet, or eyes) TO:

47. No Yes…..Novocaine or dental anesthetic?
48. No Yes…..Penicillin or other antibiotics?
49. No Yes…..Aspirin?
50. No Yes…..Codeine or other narcotics?
51. No Yes…..Other____

WOMEN

52. No Yes…..Are you pregnant or anticipating pregnancy in the near future?
53. No Yes…..Are you taking any hormones?
54. No Yes…..Are you nursing?

ORAL HEALTH HISTORY

54. No Yes…..Have you had surgery, radiation treatment or chemotherapy for a tumor growth, cancer or other condition of the head, neck or mouth?
55. No Yes…..Do you have a history of fever blisters or “cold sores”?
56. No Yes…..Do you have recurrent canker sores, mouth ulcers or oral herpes infections?
57. No Yes…..Have you had any trouble with any previous dental treatment?
58. No Yes…..Do you bleed excessively after extractions, surgery or wounds?
59. No Yes…..Do you have a dry mouth frequently?
60. No Yes…..Do you have any disease, condition, or problem not listed? If yes, please specify: ____
61. No Yes…..Do you have any hearing, visual problems or other disabilities, which we should consider in planing your dental treatment (e.g. glaucoma)? If yes please specify: ____
62. When was your last visit to a dentist? ______________________________
63. What is the usual reason for visiting a dentist?
    - Routine checkup and cleaning__________________
    - Only when I have a dental problem______________
64. Date of your last radiographs:__________________________

SOCIAL HISTORY

65. No Yes…..Do you smoke?
66. No Yes…..Do you drink alcoholic beverages?

FAMILY HISTORY

67. No Yes…..Do you have a family history of heart disease, diabetes, or immunological disease such as lupus?
68. No Yes…..Do you have any family history of muscular or brain disorder?

To the best of my knowledge, all of the preceding answers are true and correct. If I have any change I will inform the doctor at my next appointment.

Patient’s signature:______________________________ Date: ____________________