

Patient Health Survey

(Your responses are for our records only and will be considered strictly confidential)

Name: _____ Date _____

Weight _____ Height _____ Age _____

Are you presently under the care of a physician? Yes No

If yes, please explain _____

Physician _____ Phone _____

Allergies

Local Anesthetics Y N

Codeine/Narcotics Y N

General Anesthetics Y N

Penicillin(s) Y N

Aspirin Y N

Sulfa Drugs Y N

Others (please list) _____

Any skin sensitivities/allergies _____

Medications

Please list all medications that you are presently taking (such as antibiotics, pain medication, heart medication, anti-coagulates, etc.) _____

Are you required to take antibiotics before dental work? Y N

Do you have or have you ever had any of the following?

High blood pressure Y N

Tumor or growth Y N

Chest pain or angina Y N

Chemotherapy or radiation therapy Y N

Heart attack, heart disease Y N

Seizures, epilepsy Y N

Damaged heart valve, murmur Y N

Mental health problems Y N

Mitral valve prolapse (MVP) Y N

Shortness of breath Y N

Arthritis Y N

Cardiac pacemaker Y N

Jaw joint problems Y N

Stroke Y N

Osteoporosis	Y	N	
Sinusitis,seasonal allergy	Y	N	
Diabetes	Y	N	
Asthma	Y	N	
Thyroid problems	Y	N	
Emphysema	Y	N	
Anemia	Y	N	
Tuberculosis	Y	N	
Sickle cell trait/disease	Y	N	
Bruise easily	Y	N	
Abnormal or prolonged bleeding	Y	N	
Stomach ulcers	Y	N	
Liver disease, hepatitis	Y	N	
Kidney problems	Y	N	
HIV positive, ARC, AIDS	Y	N	
Problems breathing or snoring	Y	N	
Have you ever had surgery in the past (including facial surgery)?	Y	N	_____
Have you ever had facial radiation?	Y	N	_____
Do you develop keloid or hypertrophic scars?	Y	N	
Use of blood thinners	Y	N	
Use of steroids	Y	N	
Viral Lesions – Herpes Simplex – Cold Sores	Y	N	Date _____
Auto Immune Disease	Y	N	
Fibromyalgia	Y	N	
Scleroderma	Y	N	
Lupus	Y	N	
Rheumatoid Arthritis	Y	N	
Eczema	Y	N	
Active Acne	Y	N	
Hepatitis	Y	N	
Do you smoke?	Y	N	How much? _____
Smokeless tobacco?	Y	N	Number of years _____
Do you consume alcohol?	Y	N	How much? _____
Do you have a healthy diet?	Y	N	
List any dietary concerns:			_____
Do you exercise?	Y	N	How much? _____
Do you take vitamins?	Y	N	
Multi-Vitamins:_____			Antioxidants:_____
Do you drink caffeine?	Y	N	How much? _____
Do you drink water?	Y	N	How much? _____
For women only:			
Do you have regular periods?	Y	N	
Are you going through menopause?	Y	N	
Are you pregnant or lactating?	Y	N	

