QUAKERTOWN PERIO-IMPLANT, INC.
PERIODONTICS • IMPLANTS

DONNA L. ENDY, D.M.D.

Health Questionnaire

Name: _____
Date: _____

SECTION A:

	Primary Physician:	**General Dentist:**
Name:	_____	_____
Address:	_____	_____
	_____	_____
Phone:	_____	_____

My major dental problem or reason for today's visit:_____
Date of last dental xrays: _____Your last visit: _____ Reason: _____

SECTION B:

Answer all questions by circling "Yes" or "No" and fill in all blank spaces when indicted:

1.	Yes	No	Has there been any change in your general health within the past year?
2.	Yes	No	Are you now under the care of a physician? If yes, what is the condition being treated?_____
3.	Yes	No	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.	Yes	No	Rheumatic fevere or rheumatic heart disease
5.	Yes	No	Heart murmur or congenital heart disease
6.	Yes	No	Heart trouble, heart attack, stroke
7.	Yes	No	Placement of pacemaker, or prosthetic artifical heart valve
8.	Yes	No	Shortness of breath or chest pain after mild exercise
9.	Yes	No	Shortness of breath when you lie down
10.	Yes	No	Use more than 2 pillows to sleep
11.	Yes	No	Ankles swell
12.	Yes	No	High blood pressure
13.	Yes	No	Asthma, emphysema or difficulty in breathing
14.	Yes	No	Seizures or convulsion
15.	Yes	No	Diabetes
16.	Yes	No	A loss or gain of 10 pounds or more in the past year
17.	Yes	No	Frequent urination (more than 6 times a day)
18.	Yes	No	Excessive thirst
19.	Yes	No	Hepatitis, jaundice, or liver disease
20.	Yes	No	AIDS, or positive test to HIV/HTLV-III
21.	Yes	No	Arthritis
22.	Yes	No	Cancer/Chemotherapy
23.	Yes	No	Stomach ulcers
24.	Yes	No	Kidney trouble or renal dialysis
25.	Yes	No	Tuberculosis
26.	Yes	No	A persistent cough or coughing up blood
27.	Yes	No	Venereal disease, gonorrhea, syphillis
28.	Yes	No	Psychiartic therapy
29.	Yes	No	Thyroid disease
30.	Yes	No	Any artifical bones or joints (prosthesis implanted?)

31. Yes No Any blood disorder such as anemia or sickle cell disease
32. Yes No Surgery or radiation (x-ray) treatment for a tumor, growth, cancer or other condition of your head, neck or mouth
33. Yes No Bleed excessively after you are cut
34. Yes No Ever required a blood transfusion
35. Yes No Even been denied permission to give blood
36. Yes No Any hearing, visual problems or other disabilities which we should consider in planning your dental treatment (i.e. glaucoma)
37. Yes No Ever been in contact with any individuals having hepatitis, tuberculosis or AIDS

HAVE YOU TAKEN ANY OF THE FOLLOWING MEDICATIONS IN THE PAST 6 MONTHS?

38. Yes No Anticoagulants (blood thinners)
39. Yes No Medicine for high blood pressure or water pills
40. Yes No Cortisone (steroids)
41. Yes No Valium, Librium, or tranquilizers
42. Yes No Aspirin
43. Yes No Insulin or pills for diabetes
44. Yes No Digitalis or drugs for heart trouble
45. Yes No Nitroglycerin or other medicine for angina pectoris (chest or heart pain)
46. Yes No Birth control pills
48. Yes No FenFen, Pondimine (fenfluramine), Redux (dexfenluramine)
49. Yes No Medicine prescribed by your physician _____
_____

ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION SUCH AS itching, burning, rash, swelling of hands, feet or eyes due to:

50. Yes No Dental anesthetic (lidocaine, carbocaine, septocaine)
51. Yes No Aspirin or NSAIDS
52. Yes No Codeine or other narcotics
53. Yes No Penicillin or other antibiotics
54. Yes No Other _____

WOMEN

55. Yes No Are you pregnant of anticipating pregnancy in near future
56. Yes No Are you taking any hormones?

ORAL HEALTH HISTORY

57. Yes No Do you have a history of fever blisters or cold sores?
58. Yes No Do you have recurrent canker sores, mouth ulcers, or oral herpes infections?
59. Yes No Have you had any trouble with any previous dental treatment?
60. Yes No Do you bleed excessively after extractions, surgery or wounds?
61. Yes No Do you have dry mouth frequently?
62. Yes No Do you have any disease, condition, or problem not listed?
If yes, please specify: _____

SOCIAL HISTORY

63. Yes No Are you addicted or recovering from any drugs or alcohol
63. Yes No Do you smoke? If yes, what? _____
How many a day _____ How many years? _____
63. Yes No Do you drink alcoholic beverages? If yes, what? _____ How much? _____

Signature: _____ Date: _____