WILMETTE DENTAL
Peter Neuhaus | DDS

Heath Questionnaire

First Name	Last Name	Occupation	Date of Birth

Physician's Name	Physician's Address	Physician's phone no.

When was your last physical exam? _____

Do you have or have you had any of the following:

YES	NO	
☐	☐	Artificial heart valve
☐	☐	Infective endocarditis
☐	☐	Joint implant or replacement (hip, knee, etc.)
☐	☐	Organ transplant
☐	☐	HIV, AIDS or other immunosuppressive disorders
☐	☐	Heart disease or angina
☐	☐	Heart attack
☐	☐	Stroke
☐	☐	Heart failure
☐	☐	Pacemaker
☐	☐	High blood pressure
☐	☐	Low blood pressure
☐	☐	Asthma
☐	☐	Sinus trouble
☐	☐	Epilepsy. fainting spells, or seizures
☐	☐	Diabetes
☐	☐	Hepatitis, jaundice, or liver disease
☐	☐	Stomach ulcers
☐	☐	Tuberculosis
☐	☐	STD (Sexually Transmitted Disease) or Venereal disease
☐	☐	Psychiatric disorder
☐	☐	Cancer
☐	☐	Thyroid disorder
☐	☐	Anemia or other blood disorders
☐	☐	Radiation treatment and/or chemotherapy
☐	☐	Have you had abnormal bleeding associated with previous extractions, surgery, or trauma?
☐	☐	Have you been told you need to take antibiotics before dental treatment
☐	☐	(Woman) Are you pregnant?

Are you allergic to or have you ever reacted adversely to:

YES	NO	
☐	☐	Latex or rubber
☐	☐	Local Anesthetics
☐	☐	Penicillin
☐	☐	Other Antibiotics
☐	☐	Aspirin
☐	☐	Codeine or other narcotics
☐	☐	Other _____

List any serious illnesses or operations not listed above:_____

_____

When was your last dental examination?_____

YES	NO	
☐	☐	Are you a smoker or tobacco user (chew)
☐	☐	Do you have dry mouth?
☐	☐	Have you ever had treatment for your gums?
☐	☐	Have you ever had orthodontic treatment (braces)?
☐	☐	Do you ever clench or grind your teeth?
☐	☐	Have you had difficulty with any previous dental treatment?
☐	☐	Are any of your teeth sensitive to temperatures, biting/chewing or sweets?
☐	☐	Are you satisfied with your teeth's appearance?
☐	☐	Would you like to change anything about your smile? Explain_____

List any medications you are now taking and the reason for their use:

Medication	Reason for use	Medication	Reason for use
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

_____ _____ _____

Patient (or guardian) Signature **Date** **Guardian's name and relationship to patient (if applicable)**

Reviewed by:

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
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