

WILMETTE DENTAL

Peter Neuhaus | DDS

Health 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 | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Artificial heart valve |
| <input type="checkbox"/> | <input type="checkbox"/> | Infective endocarditis |
| <input type="checkbox"/> | <input type="checkbox"/> | Joint implant or replacement (hip, knee, etc.) |
| <input type="checkbox"/> | <input type="checkbox"/> | Organ transplant |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV, AIDS or other immunosuppressive disorders |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart disease or angina |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart attack |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart failure |
| <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Low blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Sinus trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy, fainting spells, or seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis, jaundice, or liver disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Stomach ulcers |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> | STD (Sexually Transmitted Disease) or Venereal disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia or other blood disorders |
| <input type="checkbox"/> | <input type="checkbox"/> | Radiation treatment and/or chemotherapy |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you been told you need to take antibiotics before dental treatment |
| <input type="checkbox"/> | <input type="checkbox"/> | (Woman) Are you pregnant? |

