Dr. Kathy Cosmetic Dentistry ❖ 6325 Topanga Canyon Blvd Ste 504 ❖ Woodland Hills, CA 91367 ❖ 818-347-1550

HEALTH QUESTIONAIRE

Please answer all questions, check yes or no boxes and DO NOT leave any blank spaces where indicated. Answers to the following questions are for our records only and will be considered confidential.

Patient Name:_____ Birth Date:_____Chart#_____

1. Are you in good health? ☐ Yes ☐ No
   Your last physical was on _____ (date).
   Height:_____ Weight:_____
2. Are you now under a physician care? ☐ Yes ☐ No
   a. If so, what Is the condition being treated? _____
   b. Physician Name: _____ Phone #:_____
3. Have you had any serious illness, operation or been hospitalized? ☐ Yes ☐ No
   a. If yes, what was the problem and when? _____
4. Do you drink alcoholic beverages? ☐ Yes ☐ No
5. History of alcohol abuse? ☐ Yes ☐ No
6. Have you used any recreational drugs in the last six months? ☐ Yes ☐ No
7. History of drug abuse? ☐ Yes ☐ No
8. Do you smoke? ☐ Yes ☐ No
9. Do you use tobacco? ☐ Yes ☐ No
10. History of drug abuse? ☐ Yes ☐ No
11. Have you had or do you currently have any of the following conditions? Please check yes or no.

Heart Conditions

High Blood Pressure	☐ Yes	☐ No
Low Blood Pressure	☐ Yes	☐ No
Angina/Chest Pain	☐ Yes	☐ No
Fainting/Seizure	☐ Yes	☐ No
Irregular Heart Beat	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No
Heart Bypass	☐ Yes	☐ No
Heart Pacemaker	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Rheumatic Fever/Heart Valve Damage	☐ Yes	☐ No
Anemia	☐ Yes	☐ No

Liver Disease

Hepatitis – circle A B C	☐ Yes	☐ No

Breathing/Lung Condition

Asthma	☐ Yes	☐ No
Allergies/Hay Fever	☐ Yes	☐ No
Breathing Difficulties	☐ Yes	☐ No
Snoring/Sleep Apnea	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Sinus Problems	☐ Yes	☐ No

Immunosuppressed/Blood Disease

HIV Positive	☐ Yes	☐ No
AIDS	☐ Yes	☐ No
Sexually Transmitted Disease	☐ Yes	☐ No
Delay in Healing	☐ Yes	☐ No

Organ Condition/Disease

Pancreas/Diabetes	☐ Yes	☐ No
Kidney/Dialysis	☐ Yes	☐ No
Eyes/Glaucoma	☐ Yes	☐ No
Thyroid	☐ Yes	☐ No
Neurologic/Epilepsy	☐ Yes	☐ No

Cancer

Location:_____

Surgery	☐ Yes	☐ No
Radiation Treatment	☐ Yes	☐ No
Chemo Therapy	☐ Yes	☐ No

Joint Condition

Arthritis	☐ Yes	☐ No
Artificial knee/hip replacement	☐ Yes	☐ No
TMJ (Jaw)	☐ Yes	☐ No
Swollen Ankles	☐ Yes	☐ No

Other: _____

12. Have you had abnormal bleeding associated with previous extractions, surgery or trauma? ☐ Yes ☐ No
    a. Do you bruise easily? ☐ Yes ☐ No
    b. Have you ever required a blood transfusion? ☐ Yes ☐ No
       If yes, explain circumstances _____
13. Have you had surgery or x-ray treatment for a tumor, growth or other condition in your mouth or lips? ☐ Yes ☐ No
    If yes, date_____
14. Are you taking any drug or medicine ☐ Yes ☐ No
    If yes, list all medication(s)_____

15. Are you taking any of the following?

Antibiotics or sulfa drugs	☐ Yes	☐ No	Anticoagulants (blood thinner)	☐ Yes	☐ No
Medicine for high blood pressure	☐ Yes	☐ No	Cortisone (steroids)	☐ Yes	☐ No
Tranquilizers	☐ Yes	☐ No	Aspirin	☐ Yes	☐ No
Insulin, Tolbutamid	☐ Yes	☐ No	Nitroglycerin	☐ Yes	☐ No
Digitalis or drugs for heart problems	☐ Yes	☐ No	Other_____		

16. Are you allergic or have you reacted adversely to

Penicillin or other antibiotics	☐ Yes	☐ No	Latex	☐ Yes	☐ No
Aspirin	☐ Yes	☐ No	Local anesthetic	☐ Yes	☐ No
Barbiturates, codeine, sedatives, sleeping pills			Iodine	☐ Yes	☐ No
	☐ Yes	☐ No	Sulfa drugs	☐ Yes	☐ No

Other:_____

17. Have you had any adverse reaction associated with previous dental treatment? ☐ Yes ☐ No
    If yes, explain _____
18. Have you had any adverse reaction associated with previous medical problems? ☐ Yes ☐ No
    If yes, explain _____
19. Mental Health Problems ☐ Yes ☐ No
20. Have you had any disease, serious illness/surgery condition or problem not listed above? ☐ Yes ☐ No
    If yes, explain _____
21. Have you been on any IV Bisphosphonates for chemotherapy, i.e. Zometa or Oral Bisphosphonates in the last 5 years for osteoporosis, i.e. Fosamex or Actonel? ☐ Yes ☐ No
    If yes, explain:_____

WOMAN ONLY

Are you pregnant?	☐ Yes	☐ No	Expectant Date:_____		
Are you nursing/breastfeeding	☐ Yes	☐ No	Are you taking birth control?	☐ Yes	☐ No

NOTE: Antibiotics (such as penicillin) may alter the effect of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

I have filled out this questionnaire completely. I have advised Dr. Kathy Daroee all medical problems of which I am aware.
Print Name:_____ Signature:_____ Date:_____
Parent/Guardian if minor

I have reviewed the Patient's health history form above.
Notes:_____

Doctor's Signature:_____ Date:_____

RECALL REVIEW: _____ Month
Any changes in health history? ☐ Yes ☐ No If yes, please list changes: _____

Print Name:_____ Signature:_____ Date:_____
Doctor's Signature:_____ Date:_____

RECALL REVIEW: _____ Month
Any changes in health history? ☐ Yes ☐ No If yes, please list changes: _____

Print Name:_____ Signature:_____ Date:_____
Doctor's Signature:_____ Date:_____