DENTAL ASSOCIATES OF HERSHEY

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HEALTH QUESTIONNAIRE

Name_____**Birthdate**_____**Today's Date**_____
Address_____ **City** _____**Zip**_____
Telephone Home #_____ **Work #**_____**Cell#**_____
Dental Insurance_____ **SS #**_____
Place of Employment_____
Person Responsible for Bill_____
Physician's Name_____**Telephone#**_____

Please Circle Proper Answer for Each Question

1. **Are you in Pain?---------- -Yes or No**
2. **Have you ever had severe bleeding after cuts or extraction of teeth?---------- Yes or No**
3. **Are you under the care of a physician at the present time?---------- Yes or No**
4. **Are you taking medication at the present time?---------- Yes or No**
5. **Are you allergic to any drugs?---------- Yes or No**
6. **Are you allergic to any local anesthesia such as Novocain, xylocaine, ect?----------Yes or No**
7. **Are you on a special diet?---------- Yes or No**
8. **Has your Medical Doctor ever said you have cancer or a tumor?---------- Yes or No**
9. **Do you have any disease, condition, or problem not listed?---------- Yes or No**
10. **Women: Are you pregnant now?---------- Yes or No**

Circle any of the following which you have had or have at present:

Heart Failure	**Emphysema**	**AIDS**
Heart Disease/Attack	**Cough**	**Hepatitis A (Infectious)**
Angina Pectoris	**Tuberculosis (TB)**	**Hepatitis B (Serum)**
High Blood Pressure	**Asthma**	**Liver Disease**
Heart Murmur	**Hay Fever**	**Yellow Jaundice**
Rheumatic Fever	**Sinus Trouble**	**Blood Transfusion**
Congenital Heart Lesions	**Allergies or Hives**	**Drug Addiction**
Scarlet Fever	**Diabetes**	**Hemophilia**
Mitro Valve Prolapse	**Thyroid Disease**	**Venereal Disease**
Artificial Heart Valve	**X-ray or Cobalt Treatment**	**Cold Sore**
Heart Surgery	**Chemotherapy (Cancer/Leukemia)**	**Genital Herpes**
Heart Pacemaker	**Arthritis**	**Epilepsy or Seizures**
Artificial Joint	**Rheumatism**	**Fainting or Dizzy Spells**
Anemia	**Cortisone Medicine**	**Nervousness**
Stroke	**Glaucoma**	**Psychiatric Treatment**
Kidney Trouble	**Pain in Jaw Joints**	**Sickle Cell Disease**
Ulcers	**Bruise Easily**	**HIV Positive**

Patient, Parent or Guardian Signature_____

Reason for leaving previous dentist:_____