

HEALTH QUESTIONNAIRE

HEALTH HISTORY

Note: To help us meet your healthcare needs, please complete this form. Your answers are for our records only and will be confidential.

Patient's Name: _____ Date of Birth: _____

Medical Insurance Carrier: _____

Primary Care Physician: _____ Telephone #: _____

Date of last Physical: _____ Height: _____ Weight: _____

Please circle.

Yes No Are you in good health?

Yes No Has there been any change in your general health in the past year?

Yes No Are you now under the care of a physician for any problem?

Yes No Have you ever had any serious illness or operation? Explain _____

DENTAL HISTORY

Date of last dental treatment: _____ Reason for that visit:

When was the last time you had a full mouth series of x-rays? _____

Have you ever had trouble or problems with dental treatment?

Have you ever had any of the following?

Yes No	Trauma or fracture of your jaws or teeth	Yes No	Gum Surgery
Yes No	Root Canals	Yes No	Frequent Mouth Sores
Yes No	Braces	Yes No	Wisdom teeth removed
Yes No	Grinding or Clenching of your teeth	Yes No	Bleeding Gums

MEDICATIONS

Are you now taking?

Yes No Over-the-counter medications or vitamins?

Yes No Any kind of prescription medication?

Yes No Recreational Drugs or Steroids of any type?

ALLERGIES

Are you allergic or sensitive to any of the following?

Yes No Local anesthetics such as "Novocaine"?

Yes No Penicillin, erythromycin, or other antibiotics?

Yes No Aspirin, codeine, other narcotics, or other pain medication?

Yes No Sedatives or tranquilizers?
 Yes No Latex?

HAVE YOU HAD OR DO YOU CURRENTLY HAVE...

Yes No Rheumatic fever	Yes No Stomach Ulcers
Yes No Heart murmur or click	Yes No Seizures
Yes No Heart attack or disease	Yes No Kidney Disease
Yes No Artificial Heart Valve	Yes No Frequent Headaches
Yes No Chest Pain or Angina	Yes No Thyroid Condition
Yes No Stroke	Yes No Sinusitis
Yes No High Blood Pressure	Yes No Herpes Virus (cold sores)
Yes No Bleeding Disorder	Yes No AIDS or HIV+ infection
Yes No Artificial joint	Yes No Radiation or chemotherapy
Yes No Cancer	Yes No Psychiatric Therapy
Yes No Tuberculosis	Yes No Glaucoma or eye disease
Yes No Hepatitis or liver disease	Yes No Psychiatric Therapy
Yes No Asthma, pneumonia	Yes No Autoimmune disease
Yes No Diabetes	Yes No Chronic Illness
Yes No Abnormal bleeding	Yes No Tumor

WOMEN ONLY

Yes No Are you pregnant?
 Yes No Are you nursing?
 Yes No Are you taking oral contraceptives?

I hereby state that I have answered the entire questionnaire accurately to the best of my knowledge. This form will reveal my complete medical history and assist my doctor in providing the best care possible. I will not hold the doctor of this practice or any member of the staff responsible for any errors or omissions that I have made in the completion of this form.

 Signature of Patient

 Date

SUMMATION (For Staff Use Only)

Allergies and Reactions:

Hospitalizations:



Anthony Toney, DMD, P.C.
Family Dentistry
'Beautiful smiles through exceptional dentistry'

2585 Sparkman Drive Huntsville, AL 35810 Phone: 256.652.6161

Medications and Dosages:

Received By _____