HEALTH QUESTIONNAIRE

FAMILY Name: _____ FIRST Name: _____ Male ☐ Female ☐

PHONE NUMBERS CELLULAR : _____ HOME : _____ WORK : _____

EMAIL ADDRESS: _____ DATE OF BIRTH : _____

HOME ADDRESS: _____

REFFERAL DENTIST: _____ FAMILY DOCTOR: _____

LIST OF MEDICATION YOU TAKE

_____

_____

_____

ALLERGIES : MEDICATION AND FOOD : _____

_____

MEDICAL CONDITIONS

	YES	NO		YES	NO
Snoring			Hyperthyroidism		
Sleep Apnea			Hypothyroidism		
High Blood Pressure			Sexually Transmitted Disease		
Low Blood Pressure			HIV positive		
Heart Problems			Herpes		
Heart Valve replacement (date :)			Asthma		
Diabetic			Pulmonary Problems		
Kidney Disease			Digestive Problems		
Hepatitis A, B or C			Blood Problems		
Hip or Knee replacement (date :)			Cerebrovascular accident (Stroke) (date :)		
Anxiety			Depression		
Bipolar Disorder			Epilepsia		
Crohn Disease			Stomach Ulcer		
Glaucoma			Visual problems		
INJECTIONS done in hospital			Neurological problems		
Anemia, prolonged bleeding			Smoker (number per day :)		

MAJOR HOSPITALISATIONS

Description : _____ Date : _____

Description : _____ Date : _____

PATIENT SIGNATURE : _____ DENTIST SIGNATURE :_____

DATE : _____ DATE :_____