CBC DENTAL HYGIENE DEPARTMENT HEALTH QUESTIONNAIRE

Name_____**Date**_____
(Print name)

Address_____ **Phone# (home/work)** _____
(Street) **(City, St, Zip)**

Date of Birth_____ **Occupation**_____

Physician'sName/Address/PhoneNumber_____

Dentist's Name/Address/Phone Number_____

DATE, TYPE, and NUMBER OF LAST DENTAL X-RAYS_____

1. Have you been a patient in a hospital during the past 2 years _____ **YES NO**
2. Have you been under the care of a physician during the past 2 years? _____ **YES NO**
3. Date of last medical exam: _____
4. Have you taken any medication(s) including non-prescription during the last 2 years? _____ **YES NO**
If yes, please list: _____
5. Are you currently taking any of the following medications/drugs?

Antibiotics	**YES**	**NO**	**Cortisone/steroids**	**YES**	**NO**
Blood Pressure medications	**YES**	**NO**	**Tranquilizers/sedatives**	**YES**	**NO**
Anticoagulants (blood thinners)	**YES**	**NO**	**Insulin/diabetes medication**	**YES**	**NO**
Heart Medications	**YES**	**NO**	**Aspirin**	**YES**	**NO**
Hormones	**YES**	**NO**	**Recreational drugs**	**YES**	**NO**
Bisphosphonates	**YES**	**NO**	**Others:** _____	**YES**	**NO**

6. Are you allergic to any medication/drugs? If yes, please _____ **YES NO**
7. Do you have a known latex allergy or sensitivity to latex? _____ **YES NO**
8. Have you ever had any excessive/prolonged bleeding requiring special treat _____ **YES NO**
9. Have you had any adverse reaction to local anesthetics? _____ **YES NO**
10. WOMEN ONLLY! Are you pregnant? If YES, how many months? _____ **YES NO**
11. CIRCLE any of the following conditions which you currently have or have had:

Cardiovascular disease (specify below):
Angina pectoris
Arteriosclerosis/atherosclerosis
Artificial heart valve
Congenital heart defect
Congestive heart failure
Coronary artery disease
Heart attack (myocardial infarction)
Heart Surgery
High blood pressure
History of endocarditis
Pacemaker
AIDS/HIV+
Allergies
Anemia
Arthritis
Autoimmune disease
Blood/Bleeding disorder
Cancer/Chemotherapy/ Radiation treatment
Diabetes
Epilepsy/Seizures
Gastrointestinal disease
Hepatitis or Liver disease
Kidney/renal disease
Respiratory disease
Asthma
Bronchitis
Emphysema
Sexually transmitted disease
Stroke
Thyroid disease
Total joint replacement
Tuberculosis

12. Do you have any disease/condition/problem NOT listed above that we should know about?
If so, please explain? _____ **YES NO**
13. Are having dental pain or discomfort at this time_____ **YES NO**
14. Do you feel very nervous about having dental treatment_____ **YES NO**
15. Do you use tobacco? (cigarettes, cigars, pipe, snuff, dip chew)? _____ **YES NO**
16. Date of your last dental exam? _____
Date of your last dental cleaning? _____
17. What type of toothbrush do your use? (soft, medium, hard, electric) _____
18. Do your gums bleed when you brush or floss? _____ **YES NO**
19. Are your teeth sensitive to cold, hot, sweets, or pressure? _____ **YES NO**

The above information is true and correct to the best of my knowledge.

ADULT (18 years and older)

_____
Patient's signature

_____
Date

MINOR (and other dependents)

_____
Signature of minor patient's parent/guardian

_____
Relationship to patient/Authority to Give Consent