

DENTAL HEALTH QUESTIONNAIRE

Personal Data - Privacy Act of 1974

ARE YOU IN FLIGHT STATUS? . . . YES NO OCCUPATION/JOB: _____

ARE YOU PRESENTLY ILL OR UNDER THE CARE OF A PHYSICIAN? YES NO

IF YES, PLEASE DESCRIBE: _____

ALLERGIES (including medication, Latex, jewelry, metal, etc.): _____

CURRENT MEDICATIONS: _____
(including aspirin, over-the-counter medications, etc.): _____

HISTORY OF HOSPITALIZATIONS: _____

ANY FAMILY HISTORY OF: Heart Disease Cancer Diabetes Seizures

HAVE YOU EVER HAD OR DO YOU NOW HAVE:

	Yes	No	Don't Know		Yes	No	Don't Know		Yes	No	Don't Know
Epilepsy or Seizures				Hemophilia				Ulcers			
Fainting or dizziness				Bruise or bleed easily				Kidney problems			
Anxiety reaction				Heart problems/Angina				Venereal disease			
Stroke				Hypertension				Diabetes			
Glaucoma				Rheumatic fever				Thyroid disease			
Cold Sores (Herpes)				Heart murmur				HIV/AIDS			
Persistent cough				Mitrol valve prolapse				Arthritis			
Emphysema				Congenital heart lesions				Painful joints (incl. jaw)			
TB/PPD positive				Heart surgery				Prosthetic joint			
Asthma				Prosthetic heart valve				Hives			
Hay Fever				Pacemaker				Steroid medication			
Sinus problems				Blood transfusions				Drug addiction			
Anemia				Liver disease				Alcoholism			
Sickle cell disease				Yellow jaundice				Unexplained weight change			
G-6-PD deficiency				Hepatitis - type:				Cancer/radiation therapy			

HAVE YOU EVER BEEN TOLD THAT YOU SHOULD NOT DONATE BLOOD? -----

HAVE YOU EVER BEEN TOLD THAT YOU NEED ANTIBIOTICS BEFORE DENTAL TREATMENT? -----

FEMALES: Are you taking birth control pills? -----

Are you or might you be pregnant? Estimated delivery: _____

DO YOU HAVE ANY DISEASE, CONDITION, OR PROBLEM NOT LISTED ABOVE? Please describe: _____

Patient's signature

Date

SUMMARY OF PERTINENT FINDINGS / RECOMMENDED TREATMENT MODIFICATIONS (Dentist's use only)

B/P: _____

WELLNESS SCREEN:

Tobacco use _____

Exercise _____

Diet/nutrition _____

Alcohol use _____

Stress _____

Seat belt use _____

Dental Officer's Signature

Date

PATIENT'S IDENTIFICATION

PATIENT'S NAME (Last, First, MI)

SEX

DATE OF BIRTH

RELATIONSHIP TO SPONSOR

SERVICE

SPONSOR'S NAME

RANK/GRADE

SSN

ORGANIZATION/COMMAND

PHONE #:

DAY

EVENING