# DENTAL HEALTH HISTORY QUESTIONNAIRE

## Directions to Patients:
Answers to these questions will help the dentist decide how to treat your dental problem. Try to circle each answer YES or NO. If you cannot answer a question, do not circle an answer. **Your answers will be considered strictly confidential.**

1. What is the reason for your visit today?  
   
2. Have you ever had any unusual reactions or complications related to any dental treatment?  YES  NO
   
   If yes, please explain:  
   
3. Are you allergic or have you had a reaction to the following?   
   - Latex ..................................  YES  NO  
   - Penicillin or other antibiotics ......  YES  NO  
   - Aspirin, Ibuprofen or Tylenol ......  YES  NO  
   - Local anesthetics .....................  YES  NO  

   1. Are you currently seeing a doctor?  YES  NO
   
   If yes, please explain:  
   
2. Have you ever had a serious illness, operation, or been hospitalized?  YES  NO
   
   If yes, please explain:  
   
3. Are you taking any medications, pills, or over the counter medicines at this time?  YES  NO
   
   If yes, please list:  
   
4. Do you have allergies to any other medications?  YES  NO
   
   If yes, please list:  
   
5. Do you now have or have you had any of the following conditions?  
   - Heart Problems  YES  NO  
   - High Blood Pressure  YES  NO  
   - Anemia  YES  NO  
   - Psychiatric Care  YES  NO  
   - Heart Murmur  YES  NO  
   - Pacemaker  YES  NO  
   - Bleeding Problems  YES  NO  
   - ADD/ADHD  YES  NO  
   - Chest Pains  YES  NO  
   - Stroke  YES  NO  
   - Arthritis  YES  NO  
   - Autism  YES  NO  
   - Artificial Joints/Valves  YES  NO  
   - Arterial Grafts  YES  NO  
   - Tumor/Cancer  YES  NO  
   - TB/Tuberculosis  YES  NO  
   - Diabetes  YES  NO  
   - Kidney Problems  YES  NO  
   - Thyroid Problems  YES  NO  
   - AIDS/HIV Positive  YES  NO  
   - Radiation Therapy  YES  NO  
   - Undergoing Dialysis  YES  NO  
   - Lung Disease  YES  NO  
   - Hepatitis/Jaundice  YES  NO  
   - Osteoporosis  YES  NO  
   - Rheumatic Fever  YES  NO  
   - Asthma  YES  NO  
   - Herpes  YES  NO  
   - Transplant (Bone/Organ)  YES  NO  
   - Seizure Disorder/Epilepsy  YES  NO  
   - Tobacco Use  YES  NO  
   - Alcoholism/Drug Abuse  YES  NO  

6. Women:
   - Are you pregnant?  YES  NO  
   - Are you taking oral contraceptives?  YES  NO  
   - Are you nursing at this time?  YES  NO  
   - Are you taking hormone supplements?  YES  NO

---

I have filled out this health history to the best of my knowledge and agree to inform Neighborcare Health of any changes in my medical or dental health at the beginning of each dental appointment.

---

Patient or Guardian Signature  

Today's Date

PADID-103 – Revised 01-06-21