

HEALTH QUESTIONNAIRE FOR DENTAL TREATMENT

For use of this form, see AR40-66; the proponent agency is the Office of the Surgeon General

NAME		SSN	
UNIT	HOME TELEPHONE	OFFICE TELEPHONE	
<i>PLACE A CHECK IN THE YES OR NO COLUMN</i>		YES	NO
1. Have you been under a Health Care Provider's care in the last 2 years?			
2. Have you had any serious illness, operation or hospitalization in the past?			
3. Are you allergic to any drugs or medications?			
4. Are you presently taking any drugs or medications (to include birth control pills)?			
5. Have you ever had hepatitis or jaundice?			
6. Has there been a change in your health in the last 2 years?			
7. Do you use tobacco?			
8. Do you drink alcoholic beverages?			
9. Have you ever been sick because of dental treatments?			
10. Are you a "bleeder" or have you had excessive bleeding following dental treatment?			
11. Do you get short of breath after climbing 1 flight of stairs?			
12. Have you ever taken Fen-Phen, Pondomin, or Redux for weight loss?			
13. Have you ever had a joint replaced?			
14. Are you allergic to latex?			
15. Are you pregnant?			

CHECK CONDITIONS IF THEY APPLY TO YOU

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Heart Trouble/ChestPain | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Hives or Skin Rash | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Asthma/Hay Fever | <input type="checkbox"/> Ulcers/Stomach |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anemia (Thin Blood) |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Sexually Transmitted Disease (STD) |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Sinus Disease | <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> Cancer |

Explain any unusual medical problems:

All "yes" responses MUST be addressed here:

DATE	SIGNATURE OF PATIENT
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DATE	SIGNATURE OF DOCTOR
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RECHECK

DATE	DOCTOR'S SIGNATURE	REMARKS