CASCADE DENTAL GROUP

HEALTH QUESTIONAIRE

PATIENT NAME_____ BIRTH DATE_____

How did you hear about us? _____

Please describe your reason(s) for today's visit _____

			Patient Comments:
Are you under a physician care now?	☐ Yes	☐ No	Doctor's name/contact information
Have you ever been hospitalized or had a major surgery?	☐ Yes	☐ No	
Have you had a serious head or neck injury?	☐ Yes	☐ No	
Do you smoke, use controlled substances or pain meds?	☐ Yes	☐ No	
Are you taking any medications?	☐ Yes	☐ No	Please list
Have you ever taken Bisphosphonates or Fosamax?	☐ Yes	☐ No	IV or pills?
Are you on a special diet?	☐ Yes	☐ No	

Women: Are you

☐ Pregnant or trying to get pregnant? ☐ Taking oral contraceptives? ☐ Nursing?

Are you allergic to any of the following?

☐ Aspirin ☐ Codeine ☐ Penicillin ☐ Acrylic or Latex ☐ Metal ☐ Local Anesthetics ☐ Other

If yes, please explain_____

Do you have, or have you had, any of the following?

☐ AIDs/HIV	☐ Chest Pain	☐ Genital Herpes	☐ Irregular Heartbeat	☐ Shingles
☐ Alzheimer's Disease	☐ Cold Sores/Blisters	☐ Glaucoma	☐ Kidney Problems	☐ Sickle Cell Disease
☐ Anaphylaxis	☐ Congenital Heart Disorde	☐ Hay Fever	☐ Liver Disease	☐ Cleft Lip/Palate
☐ Anemia	☐ Cortisone Medications	☐ Headaches	☐ Low Blood Pressure	☐ Sinus Trouble
☐ Angina	☐ Diabetes	☐ Heart Attack/Failure	☐ Lung Disease	☐ Spina Bifida
☐ Arthritis	☐ Drug Addiction	☐ Heart Disease	☐ Mitral Valve Prolapse	☐ Stomach Disease
☐ Artificial Heart Valve	☐ Easily Winded	☐ Heart Murmur	☐ Pain/Locking in Jaw Joints	☐ Stroke
☐ Artificial Joint	☐ Emphysema	☐ Heart Pacemaker	☐ Parathyroid Disease	☐ Swelling (limbs)
☐ Asthma	☐ Epilepsy, Seizures	☐ Hemophilia	☐ Psychiatric Care/Depression	☐ Thyroid Disease
☐ Blood Disease	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tuberculosis
☐ Bruise easily	☐ Fainting /Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatism	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Scarlet Fever	☐ Other Serious Illness

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to the patient's health. It is my responsibility to inform the dental office of any changes in medical status.

Patient or Parent/Guardian Signature_____ Date_____