



Center for Restorative Dentistry

Stephen T. Swallow, DDS

HEALTH QUESTIONNAIRE

Date _____

Patients Name _____ Preferred Name _____ Sex _____

Address _____ City _____ State _____ Zip _____

Home Phone Number _____ SSN _____ Birthdate _____

Place of Employment _____ Work Telephone _____

Person to contact in case of emergency _____ Relationship _____

Telephone _____

In order to provide you with the best dental care possible, we require you to update this form every 18 months and appreciate your cooperation

Circle Yes or No

1. Are you now under a physicians care or have you been during the last 5 years, including hospitalization(s) and surgery? Yes No

2. Are you currently under a doctor's orders or taking any medication(s), including any birth control pills (BCPs), over-the-counter drugs, or homeopathic preparations? Yes No
Please list all medications

3. Do you have any allergies or are you sensitive to any drugs or substances such as penicillin, novocaine, aspirin, latex or codeine? Yes No

4. Have you ever bled excessively after a cut, wound, or surgery? Yes No
Have you ever received a blood transfusion? Yes No

5. Are you subject to fainting, dizziness, nervous disorders, seizures or epilepsy? Yes No

6. Have you ever had any breathing difficulty, including asthma, emphysema, chronic cough, pneumonia, tuberculosis, or any other lung disorders? Yes No
 Do you use any tobacco products? Yes No
7. Have you or your family members ever had any anesthesia related problems? Yes No
8. Do you have heart disease or a history of chest pain or palpitations? Yes No
9. Is there anything you would like to discuss alone with the doctor? Yes No
10. Do you currently use, or have a history of using recreational drugs? Yes No
11. If you are female, are you pregnant or nursing? Yes No
12. Do you have a history of heart murmur, rheumatic heart disease, open heart surgery, congenital heart disease, mitral valve prolapse or an artificial joint? Yes No

Please X any of the following conditions or therapy, which you have had in the past:

- | | | |
|---|--|--|
| <input type="checkbox"/> Heart Trouble/attack | <input type="checkbox"/> Chest pain/angina | <input type="checkbox"/> High/low BP |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> Hay fever | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Malignancy/cancer |
| <input type="checkbox"/> Nasal Obstruction | <input type="checkbox"/> HIV | <input type="checkbox"/> Radiation therapy |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Thyroid condition | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cold sores | |

Physicians Name _____

Address and Phone _____

I hereby authorize and consent to my dentist obtaining copies of my medical and dental records from current or past dentists, physicians, psychologists or hospitals and I hereby expressly authorize any dentist, physician, psychologist, hospital or any other medical/dental care provider to release copies of my records to my dentist upon request. I also authorize any health care provider who has treated me to discuss my care and treatment with my dentist. I authorize Dr. Swallow to make photographs of any and all treatment that he performs for me. These photographs may be used for scientific publications, patient and public education and professional publications as long as they do not disclose my identity.

Patient Signature _____ Doctor Signature _____

(Parents Signature if minor)