ANES

GENERAL INFORMATION AND HEALTH QUESTIONNAIRE

MED ALERT:

Name _____ Age _____ Sex _____ Date of Birth _____ Home Phone _____

Responsible Party's Name _____ SS# _____ Relationship _____

Responsible Party's Address _____
Street City State Zip Own or Rent

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

☐ Acid Reflux	☐ Bruise Easily	☐ Epilepsy or Seizures	☐ Hepatitis B/C	☐ Premedication Prior to Dental Cleaning	☐ Tuberculosis
☐ AIDS/HIV	☐ Blood Disease	☐ Fainting/Dizzy Spells	☐ Herpes	☐ Psychiatric Care	☐ Tumors or Growths
☐ Alzheimer's Disease	☐ Cancer	☐ Frequent Cough	☐ Kidney Disease	☐ Renal Dialysis	
☐ Anemia	☐ Chemotherapy or Radiation	☐ Frequent Headaches	☐ Leukemia	☐ Sickle Cell Disease	
☐ Angina	☐ Chest Pain	☐ Glaucoma	☐ Liver Disease	☐ Sinus Trouble:	
☐ Anaphylaxis	☐ Cold Sores	☐ Hay Fever	☐ Low Blood Pressure	☐ Shingles	
☐ Arthritis/Rheumatism	☐ Congenital Heart Disorders	☐ Heart Attack	☐ Lung Disease	☐ Sleep Apnea	
☐ Artificial Heart Valves	☐ Cortisone Treatments	☐ Heart Disease	☐ Mental Disorders	☐ Stomach/Intestinal Disease	
☐ Artificial Joints	☐ Diabetes	☐ Heart Problems	☐ Multiple Sclerosis:	☐ Stroke	
☐ Asthma	☐ Drug Addiction	☐ Hemophilia	☐ Pacemaker	☐ Swelling of Limbs	
☐ Back Problems	☐ Emphysema	☐ High Blood Pressure	☐ Pain in Jaw Joints	☐ Thyroid Disease/Problems	

Medications You Are Taking and Why:

_____

_____

Physician's Name: _____ Phone: _____ Date of last visit: _____

Allergies

☐ Sulfa ☐ Tetracycline ☐ Codeine ☐ Metal ☐ Latex ☐ Penicillin

Other Allergies: _____

1. Are you pregnant? _____ 2. Are You Nursing? _____ 3. Do you take any contraceptives? _____ 4. History of HPV vaccine? _____ 5. Bisphosphonates use? _____

6. Do you smoke? _____ 7. Do you chew tobacco? _____ 8. Have you ever had a problem with dental anesthetics? _____

9. Have you ever had a problem with bleeding after any type of surgery (medical or dental)? _____ 10. Do you have excessive thirst? _____

11. Have you ever been hospitalized or had a major operation in the last five years? If so, for what? _____

12. Have you ever had a serious head or neck injury? If so, when? _____

13. Do you use controlled substances? _____ 14. Have you had a recent weight loss? _____ 15. Are you on a special diet? _____

Dental Health

Dental reason for coming to our office e.g. pain, cleaning, etc. _____

Name of last dentist _____ Date of last dental treatment _____ Reason for change _____

Have you ever had any serious problems associated with previous dental treatment? No☐ Yes☐ If yes, what? _____

Are you apprehensive of dental treatment? No☐ Yes☐ Do you grind or clench or grind your jaws while sleeping or during the day? No☐ Yes☐

Do your gums bleed while brushing or flossing? No☐ Yes☐ Do you have problems eating? No☐ Yes☐

Do you avoid brushing any part of your mouth because of pain? No☐ Yes☐ Do you have frequent headaches or sore neck and jaw muscles? No☐ Yes☐

Do your gums feel tender or swollen? No☐ Yes☐ Do you floss? No☐ Yes☐ If yes, how often? _____

Does your jaw pop or click? No☐ Yes☐ Are you happy with the appearance of your teeth? No☐ Yes☐

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 my (or patient's) health.

Signature: _____ Date: _____

Reviewer's Signature: _____ Date: _____

For Future Use

Changes in health or medications: _____

Sign: _____ Date: _____ Reviewed By: _____

Changes in health or medications: _____

Sign: _____ Date: _____ Reviewed By: _____