Hilde Family Dentistry

Jason L. Hilde, D.D.S., P.L.L.C.

Health Questionnaire

1) Primary Care Physician's Name _____ Location/Phone Number _____

2) Have you been under the care of a medical doctor during the past two years? ..... ☐ Yes ☐ No
   If yes, please specify _____

3) Have you been a patient in the hospital during the past five years? ..... ☐ Yes ☐ No
   If yes, please specify _____

4) Are you taking any medications, drugs or pills now?..... ☐ Yes ☐ No
   If yes, please list name and dosage on back of page →

5) Have you ever had allergic/adverse reactions to anesthetics, antibiotics or other medications? ..... ☐ Yes ☐ No
   If yes, please specify _____

6) Are you required to take antibiotics prior to dental treatment? ..... ☐ Yes ☐ No

7) Have you ever taken Fen-Phen, Pondimen, or Redux for weight loss? ..... ☐ Yes ☐ No
   If yes, did you have a medical exam for heart tissues?..... ☐ Yes ☐ No

8) Women: Taking birth control pills?* _____ Pregnant? If yes, how far along: _____ Nursing?_____
   * If yes, please be advised that if you take antibiotics, an alternate method of birth control must be used.

9) Are you currently, or have you ever been, a smoker? ..... ☐ Yes ☐ No
   If yes, how many cigarettes per day, at what age did you start, and what year did you quit? _____

10) Indicate which of the following you have had, or have at present. Check "Yes" or "No" for each item.

Heart (Disease, Surgery, Attack)....	☐ Yes	☐ No	Tuberculosis.....	☐ Yes	☐ No
Rheumatic Fever.....	☐ Yes	☐ No	Asthma.....	☐ Yes	☐ No
Heart Murmur.....	☐ Yes	☐ No	Latex Sensitivity.....	☐ Yes	☐ No
High Blood Pressure.....	☐ Yes	☐ No	Sinus Trouble.....	☐ Yes	☐ No
Mitral Valve Prolapse.....	☐ Yes	☐ No	Radiation Therapy.....	☐ Yes	☐ No
Artificial Heart Valve.....	☐ Yes	☐ No	Chemotherapy.....	☐ Yes	☐ No
Heart Pacemaker.....	☐ Yes	☐ No	Tumors.....	☐ Yes	☐ No
Arthritis/Rheumatism.....	☐ Yes	☐ No	Hepatitis (A, B, or C).....	☐ Yes	☐ No
Cortisone Medication.....	☐ Yes	☐ No	HIV Positive.....	☐ Yes	☐ No
Stroke.....	☐ Yes	☐ No	Blood Disorder (Anemia, etc.)..	☐ Yes	☐ No
Artificial Joint (Hip, Knee, Etc.)...	☐ Yes	☐ No	Sickle Cell Disease.....	☐ Yes	☐ No
Kidney Trouble.....	☐ Yes	☐ No	Liver Disease.....	☐ Yes	☐ No
Ulcers.....	☐ Yes	☐ No	Neurological Disorders...	☐ Yes	☐ No
Diabetes (Type 1 or 2).....	☐ Yes	☐ No	Epilepsy or Seizures.....	☐ Yes	☐ No
Thyroid Problems.....	☐ Yes	☐ No	Fainting or Dizzy Spells.....	☐ Yes	☐ No
Emphysema.....	☐ Yes	☐ No	Psychiatric Care.....	☐ Yes	☐ No

11) Do you have, or have you had, any disease, condition or problem not listed?..... ☐ Yes ☐ No
   If yes, please specify _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify Dr. Hilde of changes in my health or medication.

Patient/Guardian Signature _____ Date _____