MORRISON
COSMETIC DENTISTRY

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HEALTH QUESTIONNAIRE

Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

Name:	Date of birth:	Phone:	☐ Male ☐ Female
Physician:	Physician Phone:	Date of last visit:	
If you are completing this form for another person, what is your relationship to the person?			

1.	Are you currently under the care of a physician? If yes, what is the condition being treated?	YES ☐	NO ☐
2.	Have you had any serious illness, operation, or been hospitalized within the past 5 years? If yes, what was the illness or problem?	YES ☐	NO ☐
3.	Are you currently taking, or have you taken within the last week, any over-the-counter medicines? If yes, what medicines?	YES ☐	NO ☐
4.	Have you ever taken the diet control drug Fen-Phen? If yes, for how long?	YES ☐	NO ☐

5.	**Are you allergic to, or have you reacted adversely to, any of the following:**	**YES**	**NO**	**Comments:**
Local anesthetics		☐	☐	
Penicillin/tetracycline/other antibiotics		☐	☐	
Sulfa drugs		☐	☐	
Barbiturates/sedatives/sleeping pills		☐	☐	
Aspirin		☐	☐	
Codeine/other narcotics		☐	☐	
Iodine		☐	☐	
Metals (e.g., nickel, mercury, metal jewelry, etc.)		☐	☐	
Latex rubber		☐	☐	
Other, please list:		☐	☐	

6.	Do you now have, or have you ever had, any of the following:							
	YES	NO		YES	NO		YES	NO
High blood pressure	☐	☐	Environmental allergies	☐	☐	Thyroid problems	☐	☐
Low blood pressure	☐	☐	Asthma/ hay fever	☐	☐	Arthritis	☐	☐
Chest pain upon exertion	☐	☐	Sinus trouble	☐	☐	Emphysema	☐	☐
Shortness of breath	☐	☐	Hives/skin rash	☐	☐	Bronchitis	☐	☐
Fainting spells/seizures	☐	☐	Unusual weight loss	☐	☐	Tuberculosis	☐	☐
Rheumatic heart disease	☐	☐	Persistent diarrhea	☐	☐	Sexually transmitted disease	☐	☐
Rheumatic fever	☐	☐	Diabetes	☐	☐	AIDS/HIV infection	☐	☐
Heart attack/stroke	☐	☐	Urinate frequently	☐	☐	Alcohol/drug abuse	☐	☐
Heart disease/angina	☐	☐	Frequently dry mouth	☐	☐	Epilepsy	☐	☐
Damaged heart valve	☐	☐	Hepatitis/jaundice	☐	☐	Anemia/leukemia	☐	☐
Cardiac pacemaker	☐	☐	Liver disease	☐	☐	Blood clotting problems	☐	☐
Heart murmur	☐	☐	Gall bladder trouble	☐	☐	Cancer /tumor or growth	☐	☐
Mitral valve prolapse	☐	☐	Kidney/bladder trouble	☐	☐	Anorexia/bulimia	☐	☐
Ankles swell	☐	☐	Stomach ulcers	☐	☐	Frequent headaches	☐	☐
Joint replacement	☐	☐	Mental health problems	☐	☐	Color blindness	☐	☐
Blood transfusion	☐	☐	Contact lenses	☐	☐			

7.	Please list any prescription medications you are currently taking:		
	Medication Name	# of Milligrams	# of Tablets Taken Daily

	WOMAN ONLY:	YES	NO
8.	Are you pregnant? If yes, what is your due date:	☐	☐
9.	Are you currently nursing?	☐	☐
10.	Do you have any problems associated with your menstrual period?	☐	☐
11.	Are you on hormone replacement therapy? Please list:	☐	☐
12.	12. Are you on birth control pills/fertility drugs? Please list:	☐	☐

DENTAL HISTORY:				
13.	Date of your last cleaning:	Last exam:		
14.	Date of your last full series x-rays:	Last cavity detection (bitewing) x-rays:		
15.	Name of dentist you saw?		YES	NO
16.	Do your gums bleed while brushing or flossing?		☐	☐
17.	Are your teeth sensitive to hot, cold, or sweets?		☐	☐
18.	Do you get frequent fever blisters, mouth ulcers, or sores on your lips or in your mouth?		☐	☐
19.	Have you ever had burning of the tongue or cracking of the corners of your mouth?		☐	☐
20.	Do you chew or smoke tobacco in any form? Please list: what and how much/day:		☐	☐
21.	Have you had any head, neck, or jaw injuries?		☐	☐
22.	Do you notice popping, clicking, or soreness of the jaws or points just in front of the ears?		☐	☐
23.	Do you clench or grind your teeth? If yes, when:		☐	☐
24.	Have you had any serious trouble associated with any previous dental treatment? If yes, please explain:		☐	☐
25.	Have you ever had orthodontic treatment? If yes, date of placement:		☐	☐
26.	Do you wear dentures or partials? If yes, date of placement::		☐	☐
27.	Are you having any specific problems with your teeth, gums, or mouth at this time? If yes, please explain:		☐	☐
28.	Are you happy with your smile?		☐	☐

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her team, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient/Parent:_____ Date:_____

I do hereby authorize the release of any pertinent information regarding my medical or dental history to other healthcare professionals, as deemed necessary by this office

Signature of Patient/Parent:_____ Date:_____

MEDICAL HISTORY UPDATE:			
Date:	**Patient/Parent Signature:**	**Date:**	**Patient/Parent Signature:**