HEALTH QUESTIONNAIRE

PLEASE CIRCLE (Y) YES OR (N) NO
TO **ALL** OF THE FOLLOWING

NAME:______________________________ DATE:__________________

1] CARDIOVASCULAR DISEASE?

Y N High Blood Pressure. If YES, what is your BP? _____
Y N Low Blood Pressure. If YES, what is your BP? _____
Y N Arteriosclerosis
Y N Heart Attack. If YES, when? ______________
Y N Heart By-Pass Surgery. If YES, when? ____________
Y N Prosthetic Heart Valves
Y N Congenital Heart Malformations
Y N Hypertrophic Cardiomyopathy
Y N Mitral Valve Prolapse
Y N Heart Murmur
Y N Rheumatic Fever
Y N Bacterial Endocarditis
Y N Other

2] OTHER:

Y N Diabetes? Taking Insulin?
Y N Insulin Name: _______________
Y N Blood Transfusion since 1980?
Y N Hepatitis: A___B____C____
Y N Liver Disease
Y N Stomach Ulcers
Y N Kidney Problems
Y N Arthritis or Rheumatism
Y N Tuberculosis
Y N AIDS virus or HIV
Y N Epilepsy
Y N Abnormal Bleeding
Y N Anemia
Y N Cancer
Y N Have you had any joint (knee, hip, etc.) replacements?
Y N Are you pregnant?
How many months?_____
Y N Sinus Trouble
Y N Hay Fever
Y N Asthma
Y N Cocaine Use
Y N Have you ever been treated for drug addiction?
Y N Do you require antibiotics prior to dental treatment?
Y N Other

3] ARE YOU ALLERGIC TO ANY OF THESE MEDICATIONS? If YES, please indicate your reaction.

Y N Penicillin/Antibiotics
Y N Sulfa Drugs
Y N Codeine
Y N Iodine
Y N Aspirin
Y N Local Anesthetic
Y N Latex
Y N Other ______________

4] Any change in your general health?

Explain:____________________________________

____

5] ARE YOU CURRENTLY TAKING MEDICATIONS?

Y N Sulfa Drugs
Y N High Blood Pressure
Y N Tranquilizers
Y N Aspirin
Y N Antihistamines
Y N Cortisone
Y N Digitalis
Y N Drugs for Heart Disease
Y N Antibiotics
Y N Vitamins and/or Herbals
Y N Appetite Suppressants
Name of Antibiotic: _________________
Date Antibiotic started: ______________

6] Please list the names of all prescription and over-the counter medications you are currently taking or have taken in the past 10 days and the dosage of each.

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7] Have you had difficulty getting numb or staying numb during previous dental treatment?
Explain:

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8] Have you had any serious illness or operations within the past (5) years?
Explain:

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9] Personal Physician:
Name:____

Address:______________________________________

Please sign your name after carefully completing this form.

Name:____

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Endodontist: Joseph B. Suffridge, D.D.S., P.A.