



Tommy Fong DDS
 Vivian M Bennett DDS
 & Associates
 Since 1973

735 North 185th Street • Shoreline WA 98133 • 206 542 7000

B.P. _____

Pulse: _____

HEALTH QUESTIONNAIRE

Name _____ Date _____

Birthdate _____ Height _____ Weight _____ Sex _____

Medical Doctor's Name _____ Medical Doctor's Phone (_____) _____

Medical Doctor's Address _____

Previous Dentist's Name _____ Phone (_____) _____ Last seen _____

Why are you now seeking dental treatment? _____

Please circle your response.

1. Have you ever been told by a physician that you have a **heart murmur**? Yes No
2. Has your physician ever recommended that you be **pre-medicated** with antibiotics before dental treatment? Yes No
3. Do you now have or have you ever had any **heart trouble**? (i.e. Rheumatic fever, angina, etc.) Yes No
4. Do you have **high blood pressure**? Yes No
5. Do you have any **artificial prostheses** in your body? Yes No
 (i.e. metal screws, plates, pins, etc. Please specify) _____
6. Have you ever experienced any unusual **reactions or allergies** to any of the following drugs:

A. Penicillin Yes No B. Other antibiotics Yes No C. Codeine Yes No D. Aspirin Yes No	E. Sulfa drugs Yes No F. Other medicines (please specify) Yes No G. _____ H. _____
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Please list all current medications and herbal or supplements you are taking:

Name of Medication/Supplement	Dosage/mg	Frequency	Condition
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

7. Do you have any **allergies** (to foods, dust, latex, metal, etc.) Yes No
8. Do you now or have you ever used tobacco products? Yes No
9. Have you been examined by a physician within the last year? Yes No
10. Has there been any change in your general health in the past year? Yes No
11. Have you lost or gained weight in recent months? Yes No
12. Have you ever been seriously ill? Yes No

Please continue on the reverse side →

13. Have you ever been hospitalized? If yes, please explain. _____ YesNo

14. Have you ever had a blood transfusion? YesNo

15. Have you ever been treated for a growth or a tumor in any part of your body? YesNo

16. Are you frequently ill? YesNo

17. Do you often feel exhausted or fatigued? YesNo

18. Have you ever had a painful or swollen joint? YesNo

19. Do you bleed for a long time when you cut yourself? YesNo

20. Have you ever had any of the following diseases or conditions:

A. Jaundice (yellow skin & eyes) YesNo

B. Hepatitis YesNo

C. HIV (AIDS) YesNo

D. Tuberculosis YesNo

E. Venereal disease YesNo

F. Heart attack YesNo

G. Stroke YesNo

H. Ulcers YesNo

I. Epilepsy YesNo

J. Diabetes (sugar disease) YesNo

K. Measles YesNo

L. Chicken pox YesNo

M. Mumps YesNo

N. Polio YesNo

O. Rheumatic fever YesNo

P. Scarlet fever YesNo

Q. Herpes YesNo

R. Glaucoma YesNo

21. Do you have any blood disorder such as anemia (thin blood)? YesNo

22. Do you have any chest pain on exertion? YesNo

23. Are you ever short of breath on mild exertion? YesNo

24. Do your ankles ever swell? YesNo

25. Do you have a persistent cough? YesNo

26. Do you have asthma? YesNo

27. Do you ever have hay fever? YesNo

28. Do you ever have hives or skin rash? YesNo

29. Have you ever experienced an unusual reaction to a dental anesthetic (Novocaine)? YesNo

30. Do you usually have to urinate frequently? YesNo

31. Are you thirsty much of the time? YesNo

32. Has a doctor ever said you had kidney or bladder disease or infection? YesNo

33. Has a doctor ever said you had liver disease? YesNo

34. Do you have any numbness or tingling in any part of your body? YesNo

35. Has any part of your body ever been paralyzed? YesNo

36. Do you ever have fits or convulsions? YesNo

37. Do you have a tendency to faint? YesNo

38. Do you have frequent severe headaches? YesNo

39. Women — Are you presently pregnant? YesNo

This is to certify that the information above is a true representation of my health status as of this date.

Patient Signature _____ **Date** _____

Thank you for taking the time to fill out our health questionnaire.