



# Cedarwood Pleasanton Dentistry

1436 Cedarwood Lane, Ste. D, Pleasanton, CA 94566

## HEALTH QUESTIONNAIRE

**Patient's Name:** \_\_\_\_\_

Answering these questions completely is for your benefit and assures your safety during treatment.

1. Are you now under the care of a physician? Condition treated:	YES	NO
2. Have you ever had a serious illness, operation or hospitalization?	YES	NO
3. Are you taking medications? If yes, what?	YES	NO
4. Have you ever used recreational drugs (eg. Marijuana, cocaine etc...)?	YES	NO
5. Have you ever been pre-medicated with antibiotics for dental treatment? If yes, what?	YES	NO
6. Do you use tobacco in any form? If yes, what and how much?	YES	NO
7. Have you ever taken the drugs "Phen-Phen" or "Redux"?	YES	NO
8. Have you ever taken or are taking Bisphosphonate (Fosamax)?	YES	NO
9. (Women) Are you pregnant? If so, when is the due date?	YES	NO
10. (Women) Are you taking birth control pills?	YES	NO

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

### Cardiovascular System

Rheumatic Fever*	YES	NO
Heart Murmur*	YES	NO
Heart Attack	YES	NO
Shortness of breath / Ankle Swelling	YES	NO
Angina Pectoris	YES	NO
High Blood Pressure	YES	NO
Congenital Heart Disease	YES	NO
Mitral Valve Prolapse*	YES	NO
Artificial Heart Valve*	YES	NO
Pace Maker	YES	NO
Heart Surgery	YES	NO
Congestive Heart Failure	YES	NO

### Bone / Muscles

Arthritis/ Rheumatism	YES	NO
Artificial Joints/Limbs*	YES	NO

### Digestive System

Hepatitis A/B/C	YES	NO
**Please Circle which kind**		
Ulcers	YES	NO

### Endocrine

Diabetes	YES	NO
Thyroid Disease(Hyper)/ (Hypo)	YES	NO

### Allergies to Medications

Penicillin, Amoxicillin	YES	NO
Tetracycline	YES	NO
Erythromycin	YES	NO
Clindamycin	YES	NO
Sulfa Drugs	YES	NO
Codeine	YES	NO
Aspirin	YES	NO
Others	YES	NO

### Urinary

Kidney Disease	YES	NO
Burning on Urination	YES	NO
Venereal Disease	YES	NO

### Blood

Bruise Easily	YES	NO
Anemia	YES	NO
Blood Transfusion	YES	NO
AIDS / HIV*	YES	NO
Stroke	YES	NO

### Respiratory

Bronchitis	YES	NO
Asthma	YES	NO
Emphysema	YES	NO
Tuberculosis (TB)	YES	NO

### Nervous System

Epilepsy/ Seizures/ Convulsions	YES	NO
Dizziness	YES	NO
Fainting	YES	NO
Stroke	YES	NO
Psychiatric Treatment	YES	NO

### Others

Glaucoma	YES	NO
Hay Fever	YES	NO
Ringing in the Ears	YES	NO
Allergy to Latex	YES	NO
Radiation Therapy/ Chemotherapy	YES	NO
Cerebral Palsy	YES	NO
Metal Allergies	YES	NO
Tumors or Growths	YES	NO
Sinus Problems	YES	NO
Allergies / Hives	YES	NO

11. Do you have any other medical issues not mentioned above?	YES	NO
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Patient/Guardian's Signature \_\_\_\_\_

Date: \_\_\_\_\_

Reviewing Doctor \_\_\_\_\_

Date: \_\_\_\_\_

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## DENTAL HISTORY

Patient's Name: \_\_\_\_\_

1. Do you have any discomfort, pain or concerns at this time? Describe:				YES	NO
2. Have you ever had serious trouble with previous dental treatment? Describe:				YES	NO
3. Does dental treatment make you nervous?		NO	SLIGHTLY	MODERATELY	EXTREMELY
4. Have you ever been treated for Gum Disease or Periodontal Disease or Pyorrhea? If so, when?				YES	No
5. When were your last x-rays taken?					
6. When was your last dental visit?					
7. When was your last cleaning?					
8. Have you ever had trouble with local Anesthetic? What Happened?				YES	NO
9. Do you currently have, or ever had, any of the following?					
<b>Mouth</b>			<b>Teeth</b>		
Bleeding, Sore Gums	YES	NO	Loose teeth	YES	NO
Unpleasant taste / Bad Breath	YES	NO	Sensitive to hot	YES	NO
Frequent blisters	YES	NO	Sensitive to cold	YES	NO
Swelling lumps in mouth	YES	NO	Sensitive to sweets	YES	NO
Biting cheeks/ lips	YES	NO	Sensitive to biting	YES	NO
Orthodontic treatment ie braces	YES	NO	Food impaction	YES	NO
Clicking/ popping noises from jaw	YES	NO	Clenching/ Grinding	YES	NO
Difficulty opening/ closing jaw	YES	NO	Shift/ Change in bite	YES	NO
Diagnosed with TMJ problem	YES	NO			
<b>Prosthetics</b>					
Full Upper denture	YES	NO	How old?	Is it comfortable?	YES NO
Full lower denture	YES	NO	How old?	Is it comfortable?	YES NO
Partial upper denture	YES	NO	How old?	Is it comfortable?	YES NO
Partial lower denture	YES	NO	How old?	Is it comfortable?	YES NO
10. How often do you brush?		NEVER	ONCE DAILY	TWICE DAILY	AFTER EVERY MEAL
11. How often do you floss:		NEVER	INFREQUENTLY	DAILY	AFTER EVERY MEAL
12. Do you like the color of your teeth				YES	NO
13. Would you be interested in bleaching your teeth?				YES	NO

Patient/Guardian's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Reviewed by: \_\_\_\_\_

Date: \_\_\_\_\_

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*Cedarwood Pleasanton Dentistry*

**ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

I, \_\_\_\_\_ have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
{Please Print Name}

\_\_\_\_\_  
{Signature}

\_\_\_\_\_  
{Date}

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**For Office Use Only**

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**We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:**

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining the acknowledgement
- Other ( Please Specify)

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