Otis R. Washington, D.D.S., M.S., P.A.
Diplomate of the American Board of Periodontology

Dear Patient: The following information about your health history is necessary in order to provide you with the best possible care in a safe way. Incorrect information may be dangerous to your health. **ALL** questions must be answered completely and accurately. If you do not understand a question, or are unsure of the answer, or want to discuss it with Dr. Washington, circle or mark it. This Health History Questionnaire will become a part of your dental treatment record and will be considered confidential information. Thank you.

Patient Medical History

Name of Physician:	Phone ☎
Address	
Name of Dentist:	Phone ☎
Address	

Family History *Please list any disease or condition which may apply within your family.*

Mother:	Sibling(s):
Father:	Others:

Health

Question	Answer
1. Are you in good health?	☐ Yes ☐ No ☐ Unsure
2. Have there been any changes in your health in the last year?	☐ Yes ☐ No ☐ Unsure
3. Have you ever been hospitalized, had a major operation or serious illness?	☐ Yes ☐ No ☐ Unsure
4. Date of your last visit to your doctor? ____	Reason: ____
5. Are you currently receiving treatment or regular medical care by your doctor?	☐ Yes ☐ No ☐ Unsure
* If you answered "yes" for any of the above, please explain: ____	

6. Are you taking any of the following medications?

☐ Antibiotics or sulfa drugs	☐ Birth control pills or hormones	☐ Insulin or other drugs for diabetes	☐ Tranquilizers
☐ Anticoagulant (blood thinners)	☐ Cortisone (steroids)	☐ Nitroglycerin	☐ Others, please list:
☐ Antihistamine	☐ Digitalis or drugs for heart trouble	☐ Pain medicines or anti-inflammatories	
☐ Aspirin	☐ High blood pressure medicine	☐ Synthroid or other thyroid medication	

Question	Answer
7. Are you allergic to or have you had any unusual reactions to any medications or anesthetics?	☐ Yes ☐ No ☐ Unsure
* If yes, what medications and reactions? ____	
Have you ever had or been treated by a doctor for any of the following?	
8. HEART PROBLEMS: Damaged or artificial heart valves, heart murmur, rheumatic fever, rheumatic heart disease, congenital heart problems or heart attack?	☐ Yes ☐ No ☐ Unsure
* Have you ever been required to pre-medicate prior to dental procedures?	☐ Yes ☐ No ☐ Unsure
9. High blood pressure or stroke?	☐ Yes ☐ No ☐ Unsure
a. Do you have pain in your chest upon exertion?	☐ Yes ☐ No ☐ Unsure
b. Are you ever short of breath after mild exercise?	☐ Yes ☐ No ☐ Unsure
c. Do your ankles swell?	☐ Yes ☐ No ☐ Unsure
10. Severe or frequent headaches or sinus problems?	☐ Yes ☐ No ☐ Unsure
11. Blood disorders such as anemia or hemophilia?	☐ Yes ☐ No ☐ Unsure
12. Breathing problems, emphysema, tuberculosis or other lung problems?	☐ Yes ☐ No ☐ Unsure

Question	Answer
13. Asthma, hay fever or hives?	☐ Yes ☐ No ☐ Unsure
14. Stomach or intestinal disease, or ulcers?	☐ Yes ☐ No ☐ Unsure
15. Cancer, x-ray treatments, or chemotherapy?	☐ Yes ☐ No ☐ Unsure
16. Diabetes or blood sugar problems?	☐ Yes ☐ No ☐ Unsure
17. Hepatitis, jaundice, or liver disease?	☐ Yes ☐ No ☐ Unsure
18. Kidney infections, frequent urination, or renal (kidney) dialysis?	☐ Yes ☐ No ☐ Unsure
19. Seizures, fainting spells, numbness or other neurological problems?	☐ Yes ☐ No ☐ Unsure
20. AIDS, AIDS-related condition or HIV positive?	☐ Yes ☐ No ☐ Unsure
21. Tumors or growths?	☐ Yes ☐ No ☐ Unsure
22. Arthritis or rheumatism?	☐ Yes ☐ No ☐ Unsure
23. Phobias, severe anxieties, depression, unusual fears, or mental problems?	☐ Yes ☐ No ☐ Unsure
24. Psoriasis, seborrhea, or other skin diseases?	☐ Yes ☐ No ☐ Unsure
25. Have you lost weight without dieting or gained weight in recent months?	☐ Yes ☐ No ☐ Unsure
26, Do you have complaints regarding your eyes, ears, or nose?	☐ Yes ☐ No ☐ Unsure
27. Do you wear contact lenses?	☐ Yes ☐ No ☐ Some
28. Do you now use or have you ever used recreational drugs?	☐ Yes ☐ No ☐ Unsure
29. Do you smoke tobacco? ☐ Cigarettes ☐ Cigars ☐ Pipes	☐ Yes ☐ No ☐ Some
How much do you smoke a day?	
30. Do you drink alcohol? ☐ Beer ☐ Wine ☐ Liquor	☐ Yes ☐ No ☐ Some
How often do you drink?	
31. For women, are you pregnant or do you think you may be pregnant?	☐ Yes ☐ No ☐ Unsure
32. Are there any other problems about your health that you know of?	☐ Yes ☐ No ☐ Unsure

* If you answered "yes" for any of the above, please explain:

Dental History

33. What are your major dental concerns?	
34. Date of last dental visit?	**35.** Date of last dental x-rays?

36. Please check any statements which apply.

☐ I have my teeth cleaned at least once a year.	☐ I brush my teeth twice a day.
☐ I floss my teeth at least once a day.	☐ There is fluoride in my drinking water.
☐ I use a toothpaste that contains fluoride.	☐ I also use or have used other forms of fluoride.
☐ I am happy with the appearance of my teeth.	☐ My gums bleed when I brush, floss or eat.
☐ Food or dental floss catches in between my teeth.	☐ Some of my teeth are becoming loose.
☐ My teeth are sensitive to hot, cold, &/or pressure.	☐ Some of my teeth ache.
☐ I experience pain &/or clicking in my jaw joints.	☐ There are sores or growths in my mouth.
☐ I now have spaces between my teeth where there were no spaces previously.	
☐ I am worried about receiving dental treatment.	

Question	Answer
37. Have you ever fainted during a dental visit?	☐ Yes ☐ No ☐ Unsure
38. Have you experienced an unusual reaction to dental medication or anesthetic?	☐ Yes ☐ No ☐ Unsure
39. Have you experienced prolonged bleeding following dental treatment?	☐ Yes ☐ No ☐ Unsure
40. Have you had any other complications following dental treatment?	☐ Yes ☐ No ☐ Unsure
41. Have you had any injury to your teeth, jaws, or face?	☐ Yes ☐ No ☐ Unsure
42. Do you have any other dental concerns or complaints?	☐ Yes ☐ No ☐ Unsure

* If you answered "yes" to any of the previous questions, please explain:	

SIGNATURE OF PATIENT: I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes in my medical or dental status to Dr. Washington at the earliest possible time, & I agree to do so. I give permission for this office to obtain from my physicians &/or dentists any additional information regarding my medical history needed to provide me the best periodontal treatment possible.

* **Signature of person completing this form:** ____________________

* **Relationship to patient:** ____________________ **Date:** __________

Do Not Write Below This Line
Summery of History & Notation of Significant Findings:
Medical Hx. reviewed by: ____________________ Date: __________

Health History Updates	
Date:	Last Medical Exam:
Health Changes:	Medications:
Pt. Signature:	Reviewed by:
Date:	Last Medical Exam:
Health Changes:	Medications:
Pt. Signature:	Reviewed by:
Date:	Last Medical Exam:
Health Changes:	Medications:
Pt. Signature:	Reviewed by:
Date:	Last Medical Exam:
Health Changes:	Medications:
Pt. Signature:	Reviewed by: