River Hills Community Health Center
HEALTH QUESTIONNAIRE

Patient Name:_____ **DOB:**_____

Family Physician:_____ **Pharmacy**_____

Are you under a physician's care now? ○ Yes ○ No ○ Describe:

Have you ever been hospitalized or had a major operation? ○ Yes ○ No ○ Describe:

Have you ever had a serious head or neck Injury? ○ Yes ○ No ○ Describe:

Are you taking any medications, pills, or drugs? ○ Yes ○ No ○ List All Medications:
○ List of Medications Provided

1.	2.	3.	4.
5.	6.	7.	8.

Do you regularly take herbal medicines or dietary supplements: ○ Yes ○ No

Circle all that apply ➜ Echinacea Garlic Ginger Kava Valerian
Feverfew Gingko Ginseng St. Johns Wort Vitamin E

Women: Are You □ Pregnant/Trying to get pregnant? Number of months pregnant _____ □ Nursing?

ALLERGIES

Are you allergic to any of the following? (Check Box) □ No Known Allergies

□ Aspirin □ Penicillin □ Codeine □ Acrylic □ Metal □ Latex □ Local Anesthetics □ Other _____

Do you have, or have had, any of the following?

□ Acid Reflux
□ AIDS/HIV Positive
□ Alzheimer's Disease
□ Anemia
□ Angina
□ Anxiety (Dental Generalized)
□ Arthritis/Gout
□ Artificial Heart Valve
□ Asthma
□ Autism
□ Blood Disease
□ Blood Transfusion
□ Breathing Problem
□ Cancer _____
□ Chemotherapy/Radiation
□ Chest Pains
□ Cold Sores/Fever Blisters
□ Congenital Heart Disorder
□ Convulsions/ Seizures
□ COPD
□ Cortisone Medicine
□ Diabetes TYPE I OR II
□ Easily Winded
□ Emphysema
□ Excessive Bleeding
□ Excessive Thirst
□ Fainting Spells/Dizziness
□ Frequent Headaches
□ Heart Attack/Failure
□ Heart Murmur
□ Heart Pace Maker
□ Heart Trouble/Disease
□ Hemophilia
□ Hepatitis A, B or C
□ Herpes
□ High Blood Pressure
□ High Cholesterol
□ Kidney Problems
□ Leukemia
□ Liver Disease
□ Low Blood Pressure
□ Low Blood Sugar
□ Lung Disease
□ Lupus
□ Mitral Valve Prolapse
□ Organ Transplant
□ Pain In Jaw Joints
□ Psychiatric Care
□ Recent Weight Loss
□ Renal Dialysis
□ Rheumatic Fever/Disease
□ Rheumatoid Arthritis
□ Shingles
□ Sickle Cell Disease
□ Sinus Trouble
□ Spleen Removed
□ Steroid Therapy
□ Stomach/Intestinal Disease
□ Stroke
□ Subacute Bacterial Endocartis
□ Thyroid Disease
□ Tuberculosis
□ Tumors or Growths
□ Ulcers
□ Venereal Disease/STD/STI

Comments_____

Do you have any artificial joints? (If yes, answer questions below) ○ Yes ○ No Circle

Type: Hip Knee Ankle Shoulder Other_____

How long have you had the prosthetic joint? (date of surgery) _____ Has it been replaced more than once? ○ Yes ○ No

Do you need to take antibiotics before dental procedures? ○ Yes ○ No

Have you ever received osteoporosis therapy?(examples are Fosamax, Actonel, Bonlva, Calclmar, Intravenous Aredia, Zometa)
○ Yes ○ No

Are you taking (or have you ever taken) Xgeva (Denosumab)? ○ Yes ○ No

a) If yes, did you ever have jaw pain, swelling, and numbness In the mouth, loose teeth or gum infections? ○ Yes ○ No

Do you or have you ever had a drug/alcohol addiction? ○ Yes ○ No

a) If yes, what kind? (ex: Alcohol, Prescription drugs, Heroin, Meth, Cocaine, Marijuana) Other_____

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes _____

Is your immune system suppressed by disease, medications or treatments? ○ Yes ○ No

If you've had cancer, is it in remission? ○ Yes ○ No

Do you take a Blood Thinner? ○ Yes ○ No

Do you use tobacco? ○ Yes ○ No Frequency/Amt. _____

Kind: (ex - Cigs, Vape, Chew)_____

If yes, how interested are you in stopping your tobacco use? Check One □ Very Interested □ Somewhat Interested □ Not Interested

Dental History

Previous Family Dentist

_____

Do you have any present dental concerns? ..... ○ Yes ○ No

Describe _____

Date of last dental exam _____

Have you ever had orthodontic treatment? (braces) ..... ○ Yes ○ No

Have you ever been treated for gum disease? ..... ○ Yes ○ No

Do your gums bleed when you brush your teeth? ..... ○ Yes ○ No

Do you grind or clinch your teeth? ..... ○ Yes ○ No

Do you have frequent sores in your mouth? ..... ○ Yes ○ No

Have you had any injuries to your mouth or jaw? ..... ○ Yes ○ No

If so, explain _____

Are you interested in keeping your teeth? ..... ○ Yes ○ No

Do you have any Dental Implants? ..... ○ Yes ○ No

Do you have dentures/partials? ..... ○ Yes ○ No

Teeth sensitivity to cold or hot beverages? ..... ○ Yes ○ No

Do your teeth keep you awake at night? ..... ○ Yes ○ No

How many sugared beverages do you drink per day? _____ Week?_____

Comments

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (patient's) health. It Is my responsibility to Inform the dental office of any changes In medical status.

x_____
Signature of patient, parent, or guardian

x_____
Relationship and printed name of guardian

x_____
Date

x_____
Doctor's Signature