Ellen Donohue D.D.S. and Nathan Lukes D.D.S.

Health Questionnaire

Name _____ Sex _____ D.O. B. _____

Spouse or parent (if applicable)_____Employer_____

Home address _____

City _____ State_____Zip_____

Phone: Home (_____) _____-_____ Work (_____) _____-_____Cell (_____)_____

Please circle

1. Is there any condition in your mouth, head, or neck causing you discomfort or swelling? . . . . . yes no

2. Are you under a physician's (doctor's) care now? . . . . . .yes no

Doctor _____ Reason _____

3. Are you taking any medications at this time? . . . . . .yes no

List _____

4. Have you ever had a bleeding problem that needed medical treatment? . . . . . yes no

5. Have you ever been diagnosed with a heart murmur, heart defect, or have a pacemaker. . . . . yes no

6. Have you ever had surgery, x-ray treatment, or been hospitalized or any major illness or injury? . yes no

7. Do you use tobacco? If so, what kind? _____ How often?_____ yes no

8. Are you pregnant? If so, how many months? _____ yes no

9. Do you have any artificial joints (hip, knee, elbow) or artificial heart valves? . . . . . yes no

10. Are you currently taking or have you ever taken a bisphosphonate medication such as

Fosamax, Zometa, Actonel, Boniva, Aredia, Bonefos, Ostac, Skilid, Didronel? . . . . . .yes no

11. Have you ever had any of the following diseases? (please circle)

Rheumatic Fever	Arthritis/Rheumatism	Diabetes	Hepatitis/Liver Problems
Stomach Ulcers	Sinus trouble	Stroke	Heart Attack/Chest Pain
Asthma/Hay fever	Seizures/Fainting/Epilepsy	Tuberculosis	High/Low blood pressure
Kidney problem	Sexually transmitted disease		Other _____

12. Do you have any allergies (medication, latex, etc.)? . . . . . .yes no

13. Do you have any reason to believe you have been exposed to AIDS or HIV? . . . .yes no

14. Do you have any sores in your mouth that do not heal? . . . . . yes no

15. Is there any other information about your health we should know prior to treatment? . . . . . .yes no

List

_____

16. Do you have dental insurance? . . . . . yes no

Primary Insurance Company _____

Subscriber name _____ D.O. B. _____ ID# _____

Secondary Insurance Company_____

Subscriber name _____ D.O. B. _____ ID# _____

These answers I have given are true to the best of my knowledge. I am indicating my consent for routine dental procedures such as x-rays, cleanings, fillings, crowns, and local anesthesia by signing below.

Patient or Parental consent _____ Date _____