LDV _____
LP _____
X-RAYS _____

SANDERS & LOE, D.D.S., P.C.
3100 S. PARKER RD. #103
AURORA, COLORADO 80014

HEALTH QUESTIONNAIRE

Date_____

Name_____ Address_____
Last First Middle

City _____ State_____Zip Code _____ Daytime Phone_____

Sex _____ Height _____Weight _____ Birthdate_____ Alternate Phone _____

Emergency contact name_____Relationship _____Phone _____

If you are completing this form for another person, what is your relationship to that person? _____

Referred by:_____

In the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

1. Has there been any change in your general health within the past year ..... YES NO

2. My last physical examination was on _____

3. Are you now under the care of a physician ..... YES NO
   a. If so, what is the condition being treated _____

4. The name and address of my physician is _____
   _____
   _____

5. Have you had any serious illness or operation ..... YES NO
   a. If so, what was the illness or operation _____
   b. Do you have any prosthetic joints ..... YES NO

6. Do you have or have you had any of the following diseases or problems?
   a. Rheumatic fever or rheumatic heart disease ..... YES NO
   b. Mitral valve prolapse ..... YES NO
   c. Heart Murmur ..... YES NO
   d. Congenital heart lesions. ..... YES NO
   e. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) ..... YES NO
      1) Do you have pain in chest upon exertion ..... YES NO
      2) Are you ever short of breath after mild exercise. ..... YES NO
      3) Do your ankles swell ..... YES NO
      4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep ..... YES NO
      5) Have you had heart valve replacements ..... YES NO
   f. Allergy ..... YES NO
   g. Sinus trouble ..... YES NO
   h. Asthma ..... YES NO
   i. Hives or a skin rash ..... YES NO
   j. Fainting spells or seizures ..... YES NO
   k. Diabetes ..... YES NO
      1) Do you have to urinate (pass water) more than six times a day ..... YES NO
      2) Are you thirsty much of the time ..... YES NO
   l. Hepatitis, jaundice or liver disease. ..... YES NO
   m. Arthritis ..... YES NO
   n. Inflammatory rheumatism (painful swollen joints) ..... YES NO
   o. Stomach ulcers. ..... YES NO
   p. Kidney trouble ..... YES NO
   q. Tuberculosis ..... YES NO
   r. Do you have a persistent cough or cough up blood ..... YES NO
   s. Low blood pressure ..... YES NO

(over)

7. Have you had abnormal bleeding associated with previous extractions, surgery or trauma ..... YES NO
   a. Do you bruise easily ..... YES NO
   b. Have you ever required a blood transfusion ..... YES NO
   If so, explain the circumstances _____

   _____

8. Do you have any blood disorder such as anemia, or any blood viral disease ..... YES NO
   a. HIV or AIDS ..... YES NO

9. Have you had surgery or x-ray treatment for a tumor, growth, or other condition of your mouth and lips ..... YES NO

10. Are you taking any herbal medications ..... YES NO
    If so, what _____

11. Are you **taking** any of the following:
    a. Antibiotics or sulfa drugs ..... YES NO
    b. Anticoagulants (blood thinners) ..... YES NO
    c. Medicine for high blood pressure ..... YES NO
    d. Cortisone (steroids) ..... YES NO
    e. Tranquilizers ..... YES NO
    f. Antihistamines ..... YES NO
    g. Aspirin ..... YES NO
    h. Insulin, tolbutamide (Orinase) or similar drug ..... YES NO
    i. Digitalis or drugs for heart trouble ..... YES NO
    j. Nitroglycerin ..... YES NO
    k. Other _____

12. Are you **allergic** or have you reacted adversely to:
    a. Local anesthetics ..... YES NO
    b. Penicillin or other antibiotics ..... YES NO
    c. Sulfa drugs ..... YES NO
    d. Barbiturates, sedatives, or sleeping pills ..... YES NO
    e. Aspirin ..... YES NO
    f. Iodine ..... YES NO
    g. Codeine or other narcotics ..... YES NO
    h. Other (Latex, Sulphites, etc.) _____

13. Have you had any serious trouble associated with any previous dental or surgical treatment ..... YES NO
    If so, explain _____

    _____

14. Do you have any disease, condition, or problem not listed above that you think I should know about ..... YES NO
    If so, explain _____

    _____

15. Do you wear contact lenses ..... YES NO

16. Have you had eye pain, visual difficulty or glaucoma ..... YES NO

WOMEN

17. Are you pregnant ..... YES NO

18. Are you taking birth control pills or similar medication ..... YES NO

CHANGES IN MEDICAL HISTORY

_____

SIGNATURE OF PATIENT, PARENT OR LEGAL GUARDIAN — DATE

_____

SIGNATURE OF DENTIST — DATE