THE UNIVERSITY OF IOWA

College of Dentistry Health Questionnaire

Patient Name:______________________________

Date: ______________ Date of Birth: ______________

The University of Iowa College of Dentistry requests this information for the purpose of providing a complete and comprehensive evaluation of your dental needs. No persons outside the University will be provided this information unless properly authorized by you or required by law. Failure to provide the requested information will limit our ability to assess your needs and may result in the College being unable to accept you as a patient. Thank you.

Medical History

Clinic Use Only

Circle Below

1. Do you have (or have you ever had) any of the following?

Yes No a. allergic reaction to drugs or latex (Circle all that apply)

Latex Penicillin Aspirin Codeine Local Anesthetics Metal Other

Yes No b. heart attack or heart disease
Yes No c. stroke
Yes No d. high blood pressure
Yes No e. congestive heart failure
Yes No f. angina (chest pains)
Yes No g. irregular heart beat
Yes No h. artificial heart valve
Yes No i. rheumatic fever, rheumatic heart disease
Yes No j. bacterial endocarditis (SBE)
Yes No k. congenital heart disease
Yes No l. heart murmur or mitral valve prolapse
Yes No m. Immunosuppressive condition (Circle all that apply)

Steroid Therapy (e.g. prednisone) Radiation Therapy Chemotherapy SLE (Lupus)
Rheumatoid Arthritis HIV Organ Transplant Spleen removed Other

Yes No n. artificial joint(s) (Circle all that apply)

	Hip	Knee	Ankle	Shoulder	Other
Date(s) placed:					

Yes No o. other artificial implants or devices
Yes No p. bleeding problem, anemia, other blood disease
Yes No q. diabetes
Yes No r. thyroid disease
Yes No s. nervous system disease or seizures
Yes No t. stomach or intestinal disease
Yes No u. kidney disease
Yes No v. hepatitis (A, B, C or D)
Yes No w. other liver disease
Yes No x. arthritis (osteo or rheumatoid)
Yes No y. other muscle or joint disease
Yes No z. asthma
Yes No aa. tuberculosis
Yes No bb. other lung disease
Yes No cc. mental health condition - specify: ______________________
Yes No dd. physical or mental disabilities that may require special care
Yes No ee. Do you have or have you ever been treated for cancer?
Yes No ff. Are you or could you be pregnant?
Yes No gg. Are you nursing?
Yes No hh. Do you have difficulty hearing?

Clinic Use Only

Yes No 2. Do you have any disease, condition, or problem not listed here?
Describe:

Yes No 3. Have you ever been hospitalized or had surgery?
Describe:

Yes No 4. Do you have any undiagnosed symptoms?
Describe:

Yes No 5. Are you, or have you ever been addicted to a chemical substance?
(examples: alcohol, prescription drugs, heroin, meth, cocaine, other)

Yes No 6. Do you smoke or use tobacco products?

Yes No 7. Are you a past user of tobacco products?

Yes No 8. Do you regularly take herbal medicines or dietary supplements?
Specifically, do you take (circle all that apply):

Echinacea Garlic Ginger Kava Valerian Feverfew
Gingko Ginseng St. John's Wort Vitamin E Other: _____________

Yes No 9. Have you undergone current or past osteoporosis therapy ?
(Examples are: Fosamax, Actonel, Boniva pill form)

Yes No 10. Have you undergone current or past therapy to reduce high blood calcium (bisphosphonate therapy)? (Examples: intravenous Aredia, Zometa)

Physician List (please list your family physician and any medical specialists you see at least once a year):

Name	Address	City	Phone#	Name of Specialty

Dental History

Chief Complaint: (Why are you seeking dental care?) ______________________________

Yes No 1. Do you have regular dental check-ups?

2. When was your last dental exam? _____________

Yes No 3. Have you had any trouble associated with previous dental treatment?
If so, please explain: ____

Yes No 4. Have you noticed any lumps or sores in your mouth?

Yes No 5. Do your gums bleed when you brush your teeth?

Yes No 6. Have you ever injured your face, jaws or teeth?

Yes No 7. Do you suffer from pain in the mouth, face, eyes, neck or throat?

Yes No 8. Are you unhappy with the appearance of your teeth?

Yes No 9. Has fear ever prevented you from seeking dental treatment?

Yes No 10. Are you allergic to any metals or dental materials?

11. Circle the types of dental treatment you have experienced:

Orthodontics (braces) Dentures Root canal treatment Implants
Oral Surgery Periodontal (gum) treatment TMJ treatment Fillings
Crowns Bridges Veneers Bleaching Other: _______________