Carl Knox, DDS, PLLC

Family Dentistry

14818 Pacific Avenue • Tacoma, WA 98444 • 253-531-0638

Health Questionnaire

Name _____ _____ _____
First Middle Last Date of Birth Today's Date

Physician
Name _____ Address _____ _____
Street City State Zip Code Phone

What was the date of your last visit to a physician? _____

Reason: _____

What is your estimation of your general health? (circle one) Good Fair Poor

Why are you now seeking dental treatment? _____

_____

Completion of the following questions allows us to more completely care for your health and safeguards you and others who use our office. Answers are for our records only and are considered confidential.

DIRECTIONS
Please answer all questions

If your answer is YES to the question asked, check..... ☑
If your answer is NO to the question asked, check..... ☑

	YES	NO
Do you think your teeth are affecting your general health?	☐	☐
Do you have difficulty in chewing your food?	☐	☐
Are you dissatisfied with the appearance of your teeth?	☐	☐
Are you worried about receiving dental treatment?	☐	☐
Have you ever had a bad experience in a dental office?	☐	☐
Have you ever had sores in the mouth or on the lips that are slow to heal?	☐	☐
Have you ever had any injury to your face or jaws?	☐	☐
Do you have difficulty in opening your mouth wide?	☐	☐
Do you have bleeding gums?	☐	☐
Are you being treated for any condition by a physician now?	☐	☐
Have you been taking any medicines or drugs in the past 2 years?	☐	☐
Have you been hospitalized within the past 2 years?	☐	☐
Has there been any change in your general health in the past year?	☐	☐
Have you ever been seriously ill?	☐	☐
Have you had prolonged, unexplainable fever, sore throat, or infection?	☐	☐
Have you lost or gained more that 10 pounds in the past year?	☐	☐
Are you allergic to (i.e., itching, rash, swelling of hands, feet, or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications?	☐	☐
Have you ever had any excessive bleeding requiring special treatment?	☐	☐
When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired?	☐	☐
Do your ankles swell during the day?	☐	☐
Do you ever wake up from sleep short of breath?	☐	☐
Are you on a special diet?	☐	☐
Have you ever experienced an unusual reaction to local dental anesthetic ("Novocaine injection")?	☐	☐
Do you have any disease, condition, or problem not listed?	☐	☐
WOMEN ONLY		
Are you pregnant now?	☐	☐
Do you anticipate becoming pregnant?	☐	☐
Are you presently taking any medicine of any kind routinely (birth control, thyroid, etc.)?	☐	☐

Circle any of the following which you have had or have at present:

Heart Failure
Heart Disease
Heart Attack
Angina Pectoris
High Blood Pressure
Heart Murmur
Rheumatic Fever
Congenital Heart Lesions
Scarlet Fever
Artificial Heart Valve
Heart Pacemaker
Heart Surgery
Artificial Joint
Anemia
Stroke
Kidney Trouble
Kidney Dialysis
Ulcers
Emphysema
Persistent Cough
Tuberculosis (TB)
Asthma
Hay Fever
Sinus Trouble
Allergies or Hives
Diabetes
Thyroid Disease
X-Ray or Cobalt Treatment
Chemotherapy (Cancer, Leukemia)
Arthritis
Rheumatism
Cortisone Medicine
Glaucoma
Pain In Jaw Joints
Cancer or Tumorous Growth
Hepatitis A (infectious)
Hepatitis B (serum)
Hepatitis non A/non B
Liver Disease
Blood Transfusion
Drug Addiction
Hemophilia
Venereal Disease (syphilis, gonorrhea)
HIV/AIDS
Cold Sores
Genital Herpes
Nervousness
Epilepsy or Seizures
Dizzy Spells
Fainting
Psychiatric Treatment
Eating Disorder (Anorexia, Bulimia)
Sickle Cell Disease
Bruise Easily
Severe Headaches
Fen-Phen/Redux
Latex Allergy

_____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the dentist at the next appointment without fail.

_____ _____ _____
Date Signature of Patient, Parent, or Guardian Relationship to Patient