



ANDREW J. SPIRIDIGLOZZI, D.D.S.
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HEALTH QUESTIONNAIRE FORM

ASA

I. General Information

Name: _____

Date: _____

To Our Patients: Although Dentists treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you are taking could have an important relationship with the care that you are receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Yes No Are you in good health? Date of Birth _____ Age _____ Height: _____ Weight: _____

Yes No Have there been any changes in your general health in the past year?

Yes No Are you under the care of a physician? Date of last visit: _____
If Yes, for what are you being treated? _____

Yes No Have you had any illness, operation, or been hospitalized in the past five years?
If Yes, please list: _____

Have you had or do you currently have...				Have you had or do you currently have...			
	YES	NO	NOTES		YES	NO	NOTES
Anemia	<input type="checkbox"/>	<input type="checkbox"/>		High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	
Anesthetic Problems (Family History)	<input type="checkbox"/>	<input type="checkbox"/>		History of Drug/Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>		Infection	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>		Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding Tendency	<input type="checkbox"/>	<input type="checkbox"/>		Jaundice, Hepatitis, Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>		Kidney Trouble	<input type="checkbox"/>	<input type="checkbox"/>	
Bronchitis, Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>		Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>		Low Blood Sugar	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>		Malignant Hyperthermia	<input type="checkbox"/>	<input type="checkbox"/>	
Chemotherapy or Radiation	<input type="checkbox"/>	<input type="checkbox"/>		Mental Health Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Contact Lenses	<input type="checkbox"/>	<input type="checkbox"/>		Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	
Contagious Disease	<input type="checkbox"/>	<input type="checkbox"/>		Osteoporosis/Osteopenia	<input type="checkbox"/>	<input type="checkbox"/>	
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>		Are you pregnant/ nursing?	<input type="checkbox"/>	<input type="checkbox"/>	
Delay in Healing	<input type="checkbox"/>	<input type="checkbox"/>		(<i>estimated due date</i>)			
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		Problems with Immune System	<input type="checkbox"/>	<input type="checkbox"/>	
Dialysis	<input type="checkbox"/>	<input type="checkbox"/>		Prosthetic Knee/ Hip	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty Breathing	<input type="checkbox"/>	<input type="checkbox"/>		Removable Dental Appliance	<input type="checkbox"/>	<input type="checkbox"/>	
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>		Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>		Sexually Transmitted Diseases	<input type="checkbox"/>	<input type="checkbox"/>	
Eye Disease	<input type="checkbox"/>	<input type="checkbox"/>		Smoker	<input type="checkbox"/>	<input type="checkbox"/>	
Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>		Sores in Mouth	<input type="checkbox"/>	<input type="checkbox"/>	
Gallbladder Trouble	<input type="checkbox"/>	<input type="checkbox"/>		Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	
Hay Fever/Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>		Stroke	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Attack/Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>		Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Disease (Family History)	<input type="checkbox"/>	<input type="checkbox"/>		Thyroid Trouble	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Murmur/ Artificial Valves	<input type="checkbox"/>	<input type="checkbox"/>		TMJ-Pain & Clicking of Jaw	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>		Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	
				Tumor or Growth	<input type="checkbox"/>	<input type="checkbox"/>	

II. Allergy Information

	YES	NO	NOTES		YES	NO	NOTES
Local Anesthetic	<input type="checkbox"/>	<input type="checkbox"/>			Codeine or other Narcotics	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>			Latex Allergy	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>			Allergies other than Drug Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Sodium Pentothal, Valium or other Tranquilizers	<input type="checkbox"/>	<input type="checkbox"/>			Other Medications Please list:	<input type="checkbox"/>	<input type="checkbox"/>
					Food Allergies	<input type="checkbox"/>	<input type="checkbox"/>

III. Medications

	YES	NO	NOTES		YES	NO	NOTES
Birth Control	<input type="checkbox"/>	<input type="checkbox"/>			Bisphosphates(Actonel, Boniva, Fosamax)	<input type="checkbox"/>	<input type="checkbox"/>
Anticoagulant (Blood Thinner)	<input type="checkbox"/>	<input type="checkbox"/>					

List all medications, drugs or pills:

Note to Women: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

Yes No Is there any condition concerning your health that the Doctor should be made aware of?

If Yes, Please explain:

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. I will not hold Dr. Spiridigloizzi, or any other member of his staff, responsible for errors or omissions that I have made in the completion of this form.

Patient's (or Legal Guardian's) Signature

Date

Dentist Signature

Date