Waianae Coast Comprehensive Health Center
Dental Health Questionnaire

Patient's Name_____ Date:_____
First Middle Last

Name and Phone number of Patient's Medical Physician:_____

Last Physical Exam Date: _____

1. Currently under the care of a Physician?.....YES or NO
If YES, please describe_____

2. History of any serious illness, surgery, operation or hospitalization? .....YES or NO
If YES, please describe_____

3. Have or had any of the following?	**YES**	**NO**
a. History of rheumatic fever, heart defect, murmur, or infective endocarditis	☐	☐
b. Artificial heart valves	☐	☐
c. Pacemaker	☐	☐
d. Angina	☐	☐
e. Heart disease	☐	☐
f. Stroke	☐	☐
g. High blood pressure	☐	☐
h. Artificial joint or joint replacement	☐	☐
i. Epilepsy or seizure disorder	☐	☐
j. Diabetes	☐	☐
k. Hepatitis or liver disease, HIV/AIDS	☐	☐
l. Kidney disease or dialysis treatment	☐	☐
m. Autoimmune disease (eq:Lupus)	☐	☐
n. Cancer or Radiation treatment	☐	☐
o. Arthritis	☐	☐
p. Asthma	☐	☐.
q. Tuberculosis.	☐	☐.
r. Glaucoma	☐	☐.
s. Bleeding or Blood disorder	☐	☐
t. Venereal Disease	☐	☐
u. Substance abuse (active or recovering)	☐	☐
v. Any other medical condition not mentioned above _____	☐	☐

4. Allergic to or reacted adversely to any of the following?	**YES**	**NO**
a. Penicillin or other antibiotics	☐	☐
b. Narcotics or sedative medication	☐	☐
c. Aspirin or other anti-inflammatory	☐	☐
d. Local anesthetics (Novocain, etc)	☐	☐
e. LATEX or Nitrile products	☐	☐
g. Food dye, pine nut, or peanut allergy	☐	☐
f. Metal (eq:silver, nickel)	☐	☐
h. Other :_____	☐	☐

5. Currently using or taking any of the following?	**YES**	**NO**
a. Antibiotics or anti-viral medication.	☐	☐
b. Anticoagulants (blood thinners)	☐	☐
c. Medicine for high blood pressure	☐	☐
d. Cortisone or steroids	☐	☐
e. Nervous system medicine (anti-depressants, anti-psychotics, anti-anxiety)	☐	☐
f. Asthma or respiratory medications	☐	☐
g. Aspirin or anti-inflammatory medication.	☐	☐
h. Seizure medication (eq:Dilantin)	☐	☐
i. Medicine for osteoporosis	☐	☐
j. Diet drugs such as Phen-fen, Redux, or Pondimin	☐	☐
k. Drugs for heart trouble	☐	☐
l. Nitroglycerin	☐	☐
m. Narcotic medication	☐	☐
n. Birth control Pill	☐	☐
o. Tobacco products	☐	☐
p. Recreational drugs or substances	☐	☐
q. Any other prescription, herbal, or OTC medicine	☐	☐

6. Currently have any of the following:	**YES**	**NO**
a. Head lice	☐	☐
b. Untreated strep throat or severe sore throat pain	☐	☐
c. Fever or swollen lymph nodes	☐	☐

7. Female patients of childbearing age:	**YES**	**NO**
a. Pregnant?	☐	☐
b. How many months? _____		
c. Breastfeeding?	☐	☐

8. Additional questions for minors. Does your child have or had any of the following conditions?	**YES**	**NO**
a. Chronic ear infection with high fever	☐	☐
b. Autism	☐	☐
c. Any developmental disorders	☐	☐
d. Any learning disabilities (eq:ADD/ADHD)	☐	☐
e. History of trauma to head, mouth, or teeth	☐	☐
f. Tendency to snore or mouth breathe	☐	☐

Please list all medications (including OTC, herbals) currently being taking: _____
_____

I agree that this information is accurate.

_____ Staff initials: _____
Patient/Guardian Signature Print

Relationship to patient: ☐ Self ☐Guardian ☐ Other _____

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