Time 4:02 PM

West Michigan Dental Professionals

Date 1/30/2018

New HH 2018

Patient Name: Birth Date: Date Created:

Patient Questionaire

Are you under a medical doctor's care for any condition?	◯ Yes ◯ No	If yes	
List all surgeries you have had with the date:	◯ Yes ◯ No	If yes	
List all medications you take daily:	◯ Yes ◯ No	If yes	
Have you had artificial joint replacement or heart surgery?	◯ Yes ◯ No	If yes	
Do you use controlled substances?	◯ Yes ◯ No	If yes	
Do you use tobacco?	◯ Yes ◯ No		
Have you been told you snore/stop breathing during sleep?	◯ Yes ◯ No		
Have you ever had a sleep study done?	◯ Yes ◯ No		
Women: Are you taking oral contraceptives?	◯ Yes ◯ No		
Women: Are you pregnant?	◯ Yes ◯ No		

Are you allergic to any of the following?

Codeine	◯ Yes ◯ No	Latex	◯ Yes ◯ No
Local Anesthetics	◯ Yes ◯ No	Aspirin	◯ Yes ◯ No
Amoxicillin	◯ Yes ◯ No	Penicillin	◯ Yes ◯ No
Sulfa	◯ Yes ◯ No	Other	◯ Yes ◯ No

Medical Conditions

Do you have, or have you had, any of the following?

☐ Acid Reflux	☐ Cortisone Medicine	☐ Hepatitis A	☐ Radiation Treatments
☐ ADHD	☐ Depression	☐ Hepatitis B or C	☐ Recent Weight Loss
☐ AIDS/HIV	☐ Diabetes	☐ Herpes	☐ Renal Dialysis
☐ Alzheimer's Disease	☐ Drug Addiction	☐ High Blood Pressure	☐ Rheumatic Fever
☐ Anemia	☐ Easily Winded	☐ High Cholesterol	☐ Scarlet Fever
☐ Angina	☐ Emphysema	☐ Hives/Rash	☐ Scoliosis
☐ Arthritis	☐ Endometriosis	☐ Hypoglycemia	☐ Seizure
☐ Artificial Heart Valve	☐ Epilepsy	☐ IBS	☐ Shingles
☐ Artificial Joint	☐ Excessive Bleeding	☐ Irregular Heartbeat	☐ Sickle Cell Disease
☐ Asthma	☐ Excessive Thirst	☐ Kidney Problems	☐ Sinus Trouble
☐ Bite Guard	☐ Fainting Spells/Dizziness	☐ Leukemia	☐ Sleep Apnea
☐ Blood Clots	☐ Frequent Cough	☐ Liver Disease	☐ Spina Bifida
☐ Blood Disease	☐ Frequent Diarrhea	☐ Low Blood Pressure	☐ Stomach/Intestinal Disease
☐ Blood Transfusion	☐ Frequent Headaches	☐ Lung Disease	☐ Stroke
☐ Breathing Problems	☐ Genital Herpes	☐ Lyme Disease	☐ Swelling of Limbs
☐ Bruise Easily	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Thyroid Disease
☐ Cancer	☐ Gout	☐ Multiple Sclerosis	☐ Tuberculosis (TB)
☐ Chemotherapy	☐ Hay Fever	☐ Osteoporosis	☐ Tumors/Growths
☐ Chest Pains	☐ Heart Attack/Failure	☐ Pain in Jaw Joints	☐ Ulcers
☐ Cold Sores	☐ Heart Murmur	☐ Parkinson's Disease	☐ Venereal Disease
☐ Congenital Heart Disorder	☐ Heart Pacemaker	☐ Psoriasis	☐ Vertigo
☐ Convulsions	☐ Hemophilia	☐ Psychiatric Care	☐ Yellow Jaundice

Do you have, or have you had, any other illness or condition not listed? ◯ Yes ◯ No If yes

Signature

Signature of Patient, Parent or Guardian