Harbor Country Dental

Comprehensive Health Questionnaire

I. General Information

Full Name:

DOB: | Age: | Height: ft. in | Weight: lbs.

Patient Address: | City: | State: | Zip:

Phone # (Home/Mobile): | Alternate Phone #:

Referred by: | Occupation:

Emergency Contact: | Relationship: | Cell/Home #:

What are the results you are seeking from treatment:

How do you feel about your smile?

II. Medications and Supplements

Please list your current medications and supplements (over-the-counter and Rx):

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax, Actonel, Atelvia, Boniva, Reclast, Prolia) for osteoporosis or Paget's disease? ☐ Yes ☐ No

Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia, Zometa, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma, or metastatic cancer?
☐ Yes ☐ No
If Yes, Date treatment began:_____

III. Allergies

Do you have an allergy to iodine or local anesthetics? ☐ Yes ☐ No
Do you have allergies to any other medications? Do you have any other allergies? Please list:

IV. Surgical History

Have you had any of the following?	Yes	No	Unknown
Tonsils/Adenoids Removed:			
Oral Surgery or other surgeries involving the face or neck?			
Orthopedic total joint replacement (hip, knee, shoulder, elbow): Date:_____ If yes, have you had any complications?_____			
Other Surgeries (Please List):			

V. Dental History

Have you had any of the following?	Yes	No	Unknown
Are you currently experiencing dental pain or discomfort?			
Do your gums bleed when you brush or floss?			
Do you have bad breath?			
Are your teeth sensitive to hot, cold, sweets or pressure?			
Is your mouth dry upon waking or throughout the day?			
Have you had any periodontal (gum) treatments?			
Have you had orthodontic treatment?			
Have you had any problems associated with previous dental treatment?			
Is your home water supply fluoridated?			
Do you have earaches or neck pains?			
Do you experience tinnitus (ringing in the ears)?			
Do you have any clicking, popping, or discomfort in the TMJ?			
Do you clench or grind your teeth?			
Do you get sores or ulcers in your mouth or on your tongue or lips?			
Do you wear dentures or partials, retainers, occlusal guard or other sleep appliances?			
Have you ever had a serious injury to your head or mouth?			
Does your tongue feel too big for your mouth?			
Do you breathe through your mouth?			
Have you noticed any changes to your bite?			
Where is your tongue positioned at rest? ☐ At Top ☐ Bottom			

VI: Sleep & Breathing Conditions

Sleep position: ☐ side ☐ back ☐ stomach ☐ varies	Average hours of sleep per night? _____
Sleep location: ☐ bed ☐ couch ☐ chair ☐ other	Average hours of sleep per day? _____

Have you had any of the following?	**Yes**	**No**	**Unknown**
Do you snore?			
Do you take any medications to help you sleep?			
Do you wake often during the night?			
Do you feel rested upon waking?			
Do you regularly experience daytime drowsiness or fatigue?			
Have you been observed to stop breathing during sleep?			
Have you ever had a sleep test? (HST, PSG, or no)			
Have you previously used a CPAP device? Type:_____			
Do you currently use a CPAP device ? Type:_____			
Do you ever wake up choking or gasping?			
Do you have headaches upon waking?			
Do you have trouble breathing through your nose?			
Do you experience night sweats?			
Do you have a sleep disorder?			

VII: Health and Medical History

Have you had any of the following?	**Yes**	**No**	**Unknown**
Are you currently under the care of a physician? Name:_____ Date of last exam: _____			
Have you had a serious illness or been hospitalized in the past 5 years?			
Are you currently pregnant or nursing?			
Do you drink coffee or energy drinks? How many per day? _____			
Do you smoke tobacco or marijuana?			
Are you interested in quitting smoking, vaping, or chewing tobacco?			
Do you consume alcohol or take sedatives?			
Do you use controlled substances?			
Have you had previous injury to: head, neck, face, teeth, other?			
Do you have a prosthetic heart valve?			
Do you have a history of infective endocarditis?			
Do you have damaged valves in a transplanted heart?			
Do you have congenital heart disease? (unrepaired cyanotic CHD, repaired within 6 months, or repaired CHD with residual defects?)			

Do you have or have you experienced any of the following?

- ☐ ADD/ADHD
- ☐ AIDS or HIV infection
- ☐ Alzheimers
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Bleeding easily
- ☐ Birth defects
- ☐ Bruising easily
- ☐ Cancer of _____
- ☐ Chemotherapy
- ☐ Chronic fatigue
- ☐ Chronic pain
- ☐ Congestive heart failure
- ☐ Fibromyalgia
- ☐ COPD
- ☐ Depression
- ☐ Diabetes Type I or II
- ☐ Difficulty concentrating
- ☐ Dizziness
- ☐ Down's Syndrome
- ☐ Eating disorder
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting
- ☐ Frequent colds/flu
- ☐ Frequent ear infections
- ☐ Gastrointestinal disease or reflux
- ☐ Glaucoma
- ☐ Hearing impairment
- ☐ Heart attack
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Heart pacemaker
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ History of substance abuse
- ☐ Hypoglycemia
- ☐ Insomnia
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Memory loss
- ☐ Migraines
- ☐ Mitral valve prolapse
- ☐ Multiple sclerosis
- ☐ Muscle aches, fatigue, or spasms
- ☐ Muscular dystrophy
- ☐ Nervous system disorder
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Parkinson's disease
- ☐ Psychological Care
- ☐ Recent change in weight
- ☐ Rheumatoid arthritis
- ☐ Shortness of breath
- ☐ Skin disorder
- ☐ Sinus problems
- ☐ Slow healing sores
- ☐ Speech difficulties
- ☐ Stroke
- ☐ Swollen or painful joints
- ☐ Systemic lupus erythematosus
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers