HEALTH SURVEY QUESTIONS

Name_____ Date _____

NOTE: PLEASE CHECK THE BLANK TO THE LEFT WITH AN X IF ANSWER IS **YES.**

CARDIOVASCULAR SYSTEM

- ☐ Has a physician ever said you had heart trouble?
- ☐ Do you get out of breath easily?
- ☐ Has a physician ever said you had high blood pressure?
- ☐ Has a physician ever said you had low blood pressure?
- ☐ Have you ever had dizzy spells?
- ☐ Have you ever had rheumatic heart disease?
- ☐ Are you ankles often badly swollen?
- ☐ Have you ever had severe nose bleeds?
- ☐ Do you take drugs for your heart?

NERVOUS SYSTEM

- ☐ Do you suffer from frequent severe headaches?
- ☐ Has a physician ever told you that you had neuralgia?
- ☐ Has a physician ever told you that you had neuritis?
- ☐ Has a physician ever told you that you had neurosis?
- ☐ Have you ever had a nervous breakdown?
- ☐ Has a physician ever told you that you had epilepsy?
- ☐ Do you take drugs for your nerves?

RESPIRATORY SYSTEM

- ☐ Is your nose continually stuffed up?
- ☐ Do you have asthma?
- ☐ Do you have hay fever?
- ☐ Have you ever had tuberculosis?
- ☐ Do you smoke?
- ☐ Do you have frequent sore throats?
- ☐ Do you have sinusitis (post nasal drip)?

GASTROINTESTINAL SYSTEM

- ☐ Do you suffer from stomach trouble?
- ☐ Do you have frequent diarrhea?
- ☐ Do you have an ulcer?

ENDOCRINE SYSTEM

- ☐ Has a member of your family had diabetes?
- ☐ Do you have diabetes?
- ☐ Have you ever taken thyroid tablets?
- ☐ At what age did you reach puberty?
- ☐ Are you menstruating regularly?
- ☐ Are you pregnant?
- ☐ Do you take hormones of any kind?

GENITOURINARY TRACK

- ☐ Did a physician ever say that you had kidney or bladder trouble?
- ☐ Do you have difficulty urinating?

SPECIAL ORGANS

- ☐ Have you ever been treated for ear trouble?
- ☐ Have you ever been treated for eye trouble other than corrective lenses?

BLOOD

- ☐ Have you ever had anemia?
- ☐ Have you ever had prolonged bleeding following an extraction or cut?
- ☐ Have you ever had any blood problems?

SKIN

- ☐ Have you ever been treated for a skin disease?

BONES AND JOINTS

- ☐ Are your joints often painfully swollen?
- ☐ Have you ever had more than one fracture?
- ☐ Have you ever had more than one dislocation?
- ☐ Do you have arthritis?
- ☐ Have your jaws ever been locked, click or other similar problems?

MISCELLANEOUS

- ☐ Are you now under a doctor's care?
- ☐ Have you been outside the U.S. within the past two years?
- ☐ Have you ever had a reaction to penicillin?
- ☐ Have you ever taken penicillin?
- ☐ Are you allergic to aspirin?
- ☐ Have you lost much weight recently?
- ☐ Have you gained much weight recently?
- ☐ Do you use habit forming drugs or narcotics frequently?
- ☐ Have you ever had X-Ray treatment?
- ☐ Have you ever had an operation?
- ☐ Have you ever had a series of "shots" or injections?
- ☐ Have you ever had a general anesthesia?
- ☐ Have you ever had a local anesthesia?
- ☐ Do you have two or more alcoholic drinks a day?

INFECTIOUS DISEASES

- ☐ Are you presently being treated for infectious diseases of the eye?
- ☐ Do you have an immunity deficiency now or in the past?
- ☐ Have you ever been in contact with anyone who has acquired immune deficiency syndrome (AIDS)?
- ☐ Have you ever had an infection disease?
- ☐ Have you ever been treated for hepatitis (jaundice, yellow skin or eyes)?
- ☐ Have you ever been in personal contact with a person having jaundice?
- ☐ Have you ever had infectious mononucleosis?
- ☐ Have you ever had venereal disease?

HEALTH SURVEY QUESTIONS (PAGE 2)

NOTE: PLEASE CHECK THE BLANK TO THE LEFT WITH AN X IF ANSWER IS **YES.**

DRUGS AND MEDICATION

- ☐ Are you taking any of the following? If so, give the name.
- ☐ Antibiotics or sulfa drugs _____
- ☐ Anticoagulants (blood thinners) _____
- ☐ Medicine for high blood pressure _____
- ☐ Cortisone (steroids) _____
- ☐ Tranquilizers or sedatives _____
- ☐ Aspirin
- ☐ Insulin (orinase) or similar drugs for sugar _____
- ☐ Digitalis or drugs for heart trouble _____
- ☐ Nitroglycerin _____
- ☐ Birth control pills _____
- ☐ Diet pills _____
- ☐ Other _____

Are you allergic or have reacted to:

- ☐ Local anesthetics (Novocain)
- ☐ Penicillin or other antibiotics
- ☐ Sulfa drugs
- ☐ Barbiturates, sedatives, or sleeping pills
- ☐ Aspirin
- ☐ Iodine
- ☐ Codeine
- ☐ Other _____

SPECIAL DENTAL

- ☐ Do you have sores (cold sores, canker sores, etc.) that heal and reappear in your mouth?
- ☐ Do you grind your teeth at night?
- ☐ Do you have any abnormal oral habits (thumb sucking, reverse swallowing, etc.)?
- ☐ Do you ever suffer from pain in or about the ear?
- ☐ Have you ever had severe toothaches?
- ☐ Does your jaw ever “click” when opening or closing?
- ☐ Do you have any problem with your tonsils or adenoids?
- ☐ Have you ever had any difficulty opening your mouth (trismus)?
- ☐ Have you ever had difficulty in moving your jaw freely in all directions?
- ☐ Do your gums bleed when brushing your teeth?
- ☐ Have you noticed any bad odors or tastes?
- ☐ Have you ever had trench mouth?
- ☐ Did either your mother or father lose all their natural teeth?
- ☐ Are your teeth sensitive to hot, cold, or sweets?
- ☐ Have the front teeth separated creating spaces between them lately?
- How often do you brush your teeth? _____
- ☐ Do you daily use either dental floss or gum stimulators?
- ☐ Have you ever worn braces to straighten your teeth?
- ☐ Would you be tremendously disturbed if you had to loose your teeth and wear false teeth?

Signature of Patient,
or Legal Representative _____ Date _____