HEALTH QUESTIONNAIRE-Dr. Robert C. Kuepper, D.D.S.

Today's Date _____ Patient's Name _____ Birth date _____ Weight _____ lbs.

_____ Height _____

(*Name of person completing form (if different from patient) and relationship to patient)*

Please answer the following questions to the best of your ability, realizing that true and accurate answers are important to the delivery of quality care. All information you provide will be kept confidential.

PLEASE ANSWER BY CIRCLING YES (Y) OR NO (N) FOR EACH INDIVIDUAL QUESTION

1. Are you in good health?..... Y N
2. Has there been any change in your general health in the past year?..... Y N
3. Date of last check up by physician:_____
4. Are you currently under a physician's care?..... Y N
   If so, what for?_____
   Treating Physician's name? _____ Phone #:_____
5. Have you had any serious illness, operations or hospitalizations?..... Y N
   - If so, describe and give approximate dates_____
   _____
   _____
   _____
6. Have you ever had intravenous sedation or general anesthesia?..... Y N
7. Do you generally tolerate dental treatment well?..... Y N
8. DO YOU HAVE OR HAVE YOU EVER HAD:
   A. Heart disease that was detected at birth?..... Y N
   B. Rheumatic fever, rheumatic heart disease, heart murmur or valvular heart disease?..... Y N
   C. Cardiovascular disease (chest pain or angina, heart attack, coronary artery disease, high blood pressure, stroke, palpitations, irregular heart rate or rhythm, heart surgery, angioplasty, pacemaker?..... Y N
   D. Lung disease, (asthma, emphysema, chronic cough, bronchitis, pneumonia, TB, shortness of breath, severe cough?..... Y N
   E. Neurologic disorders (seizure, epilepsy, fainting, dizziness, nervous disorder..... Y N
   F. Blood disease (bleeding disorder, anemia, blood transfusions, do you bruise easily?..... Y N
   G. Liver disease (jaundice, hepatitis, cirrhosis?)..... Y N
   H. Kidney disease?..... Y N
   I. Diabetes?..... Y N
   J. Thyroid disease (hyper-thyroidism, or hypothyroidism, tumor)?..... Y N
   K. Arthritis? (which joints?)_____ Y N
   L. Ulcers, reflux, colitis, irritable bowel syndrome or other intestinal problems?..... Y N

M. Glaucoma?..... Y N
N. Frequent or recurring mouth sores?..... Y N
O. Implants/artificial joints anywhere in your body (heart valve, hip, knee)..... Y N
P. Radiation therapy (x-ray treatment for cancer) in the head and neck region?..... Y N
Q. Noises in the jaw joint, pain near ear when chewing, do you grind or clench teeth?..... Y N
R. Sinus or nasal problems?..... Y N
S. Any disease, drug or transplant operations that has depressed your immune system?.... Y N
T. Sleep apnea?..... Y N
U. Recurrent infections of any kind?..... Y N

9. ARE YOU TAKING OR USING ANY OF THE FOLLOWING:
A. Antibiotics?..... Y N
B. Anticoagulants (blood thinners)?..... Y N
C. Thyroid medications?..... Y N
D. Antihistames, decongestants?..... Y N
E. High blood pressure or heart medication?..... Y N
F. Steroids?..... Y N
G. Tranquilizers, antidepressants?..... Y N
H. Stomach or GI medications (antacids, etc.)?..... Y N
I. Cholesterol reducing drugs?..... Y N
J. Aspirin,ibuprofen,NSAIDS,anti-inflammatory drugs,narcotics,opiods or other pain relievers? Y N
K. Herbals, natural remedies (gingo biloba,ginger,garlic,ephedra,gingeng,etc.)?. ..... Y N
L. Marijuana, cocaine or other “recreational” drugs?..... Y N
M. Any bisphosphonate (Aredia,Zometa, Fosamax,Actonel or Boniva) now or in the past?..... Y N
N. MEN ONLY: erectile dysfunction drugs?..... Y N
O. Weight reduction pills or diet aids (over the counter or “natural” products?..... Y N
P. Any other regular medications, pills, supplements or drugs?..... Y N

PLEASE LIST ALL CURRENT MEDICATIONS HERE_____
_____
_____
_____

10. ARE YOU ALLERGIC TO OR HAD AN ADVERSE REACTION FROM:
A. Local anesthetic (Novocaine-like drugs)?..... Y N
B. Penicillin, Amoxicillin, Cephalosporins?..... Y N
C. Other antibiotics?..... Y N
D. Barbituates, sedatives?..... Y N
E. Aspirin, ibuprofen, NSAIDS or other pain medications?..... Y N
F. Codeine or other narcotics or opioids?..... Y N
G. Latex?..... Y N

H. Other allergies or reactions? Please list them_____ Y N

_____

11. Do you have hay fever, frequent skin rashes, etc.?.....Y N
12. Do you use alcohol? How much per day?_____ Y N
13. Do you smoke?..... Y N
    What product and how much per day?_____ For how long?_____
14. Do you use smokeless tobacco?.....For how long?_____ Y N
15. Are you, or have you been in a drug or alcohol recovery program?..... Y N
16. Do you have a history of any psychological or emotional disorders (e.g. depression,anxiety)……. Y N
17. Do you have any other disease, condition or problem not listed above that you think your doctor should know about?..... Y N
18. Do you wish to talk to the doctor privately about anything?..... Y N
19. WOMEN:
    A. Are you taking birth control pills?.....Y N
    B. Are you pregnant, trying to become pregnant or any change you might be pregnant?.....Y N
    C. Are you breast feeding?.....Y N
    D. Are you taking hormonal replacements?..... Y N
20. Is there anything else in your health history about which you have not been asked in this questionnaire that might be important for your oral surgeon to know? If in doubt, please err on the side of safety and list it here:_____ .

I understand the important of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.

_____ _____ _____

Date Signature of person completing Health History Dr.'s Initials

Thank you. Please return this form to the receptionist before completing others.

FOR COMPLETION BY THE DOCTOR:
Significant medical findings:

_____
_____
_____

ASA: ( ) Dental Management Considerations:

____Antibiotic premedication ____ Coumadin/Anticoagulant ____ Steroids
____ Beta Blocker ____ Bisphosphonates ____ Medical Consultation

Medical History Update:

Date: _____ Interval Changes: _____ Dr.'s Initials:_____

_____
_____
_____
_____