DEBORA ZIVARI, D.D.S. *(718) 520-9106*

HEALTH QUESTIONAIRE

For your welfare and our efficiency of diagnosis and treatment, please fill in this confidential form completely on both sides.

Referred by _____ Date _____

Name _____ Address _____
Last First Middle Number, Street

City _____ State _____ Zip Code _____ Home Phone _____ Business Phone _____

Business Address _____

Date of Birth _____ Sex _____ Height _____ Weight _____ Occupation _____

Social Security No. _____ Name of Spouse _____

SINGLE ____
WIDOWED ____
MARRIED ____
DIVORCED ____
SEPARATED ____

Closest Relative _____ Phone _____

Name of Dental Insurance (if applicable) _____

Name and Address of Physician _____ Phone _____

Reason for visit _____

Please answer each question. Check yes or no. If in doubt, leave blank.

	YES	NO
1. Are you in good health now?	☐	☐
2. Are you now under the care of a physician?	☐	☐
If so, what is the condition being treated? _____		
3. Have you ever been hospitalized or had a serious illness?	☐	☐
If yes, explain _____		
4. Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously?	☐	☐
5. (Women) Are you pregnant? If so, give due date _____	☐	☐
6. Do you use tobacco in any form? If yes, how much _____	☐	☐
7. Do you use alcoholic beverages (more than 2 drinks per day)?	☐	☐
8. Are you under excess stress or pressure at home or work?	☐	☐
9. Do you have or have you ever had any of the following?		

GENERAL	YES	NO
Tire easily, weakness	☐	☐
Marked weight change	☐	☐
Night sweats	☐	☐
Persistent fever	☐	☐
SKIN		
Eruptions (rash) hives	☐	☐
Change in skin color	☐	☐
EYES		
Visual change	☐	☐
Glaucoma	☐	☐
EARS		
Loss of hearing	☐	☐
Ringing in ears	☐	☐
NOSE		
Frequent nosebleeds	☐	☐
Sinus problems	☐	☐
THROAT		
Frequent colds	☐	☐
Soreness/hoarseness	☐	☐
NERVOUS SYSTEM		
Stroke	☐	☐
Headaches	☐	☐
Convulsions/epilepsy	☐	☐
Numbness/tingling	☐	☐
Dizziness/fainting	☐	☐
Psychiatric treatment	☐	☐

HEART/BLOOD VESSELS	YES	NO
Rheumatic fever	☐	☐
Heart murmur	☐	☐
Chest pain/discomfort	☐	☐
Heart attack/trouble	☐	☐
Shortness of breath	☐	☐
Swelling of ankles	☐	☐
High blood pressure	☐	☐
Congenital heart disease	☐	☐
Artificial heart valve	☐	☐
Pacemaker	☐	☐
Heart surgery	☐	☐
Other _____		
RESPIRATORY		
Tuberculosis	☐	☐
Emphysema	☐	☐
Asthma/hay fever	☐	☐
Persistent cough	☐	☐
Sputum production (phlegm)	☐	☐
Cough up bloody sputum	☐	☐
Difficulty breathing while lying down	☐	☐
ENDOCRINE		
Diabetes	☐	☐
Family history of diabetes	☐	☐
1) Do you urinate more than 6 times/day	☐	☐
2) Are you thirsty often	☐	☐
3) Does your mouth become dry	☐	☐
Thyroid condition/goiter	☐	☐
Other _____		

BONE/MUSCLES	YES	NO
Arthritis/rheumatism	☐	☐
Artificial joints	☐	☐
DIGESTIVE SYSTEM		
Hepatitis	☐	☐
Jaundice	☐	☐
Ulcers	☐	☐
Liver disease	☐	☐
Change in appetite	☐	☐
Vomit frequently	☐	☐
Black, bloody or pale stools	☐	☐
Frequent indigestion	☐	☐
URINARY		
Kidney disease	☐	☐
Increase in frequency of urination (night)	☐	☐
Burning on urination	☐	☐
Urethral discharge	☐	☐
Bloody urine	☐	☐
Venereal disease	☐	☐
BLOOD		
Bruise easily	☐	☐
Anemia	☐	☐
Blood transfusion	☐	☐
OTHER		
Radiation therapy	☐	☐
Tumors or growths	☐	☐
Cancer	☐	☐
Immune system disorders	☐	☐
AIDS, HIV, ARC	☐	☐

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10. Are you ALLERGIC or have you ever experienced any reaction to the following?

	YES	NO		YES	NO		YES	NO
Local anesthetics (e.g. novocaine)	☐	☐	Penicillin	☐	☐	Aspirin or codeine	☐	☐
Barbiturates/sedatives/sleeping pills	☐	☐	Erythromycin	☐	☐	Sulfa drugs	☐	☐
Codeine	☐	☐	Tetracycline	☐	☐	Other allergies _____		
Iodine	☐	☐	Narcotics	☐	☐			

11. Are you taking any of the following?

	YES	NO		YES	NO
Antibiotics/sulfa drugs	☐	☐	Insulin or similar drug	☐	☐
Blood thinners	☐	☐	Tranquilizers	☐	☐
Blood pressure medication	☐	☐	Hormone therapy	☐	☐
Thyroid medicine	☐	☐	Insulin/other diabetes drugs	☐	☐
Cortisone/steroids	☐	☐	Recreational drugs	☐	☐
Vitamins	☐	☐	Digitalis/other heart medications	☐	☐
Antihistamines/allergy drugs/ cold remedies	☐	☐	Nitroglycerin	☐	☐
			Birth control pills	☐	☐
AZT	☐	☐	Aspirin	☐	☐
			Other medication _____		

If yes to any of the above, list ***name*** of medication and ***dosage*** below:

1. _____
2. _____
3. _____
4. _____

12. Is there any disease, condition or problem not listed above that you think we should know about, or is there any activity your doctor says you cannot do? If so, explain _____

_____

_____

13. Have you ever had any serious trouble associated with previous dental treatment? _____

_____

14. Does dental treatment make you nervous? No _____ Slightly _____ Moderately _____ Extremely _____

15. Date of last dental visit _____

16. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? _____

If so, when? _____

17. Do you have or have you ever had any of the following?

MOUTH	YES	NO		YES	NO
Bleeding, sore gums	☐	☐	Loose teeth	☐	☐
Unpleasant taste/bad breath	☐	☐	Sensitive to hot	☐	☐
Burning tongue/lips	☐	☐	Sensitive to cold	☐	☐
Frequent blisters, lips/mouth	☐	☐	Sensitive to sweets	☐	☐
Swelling/lumps in mouth	☐	☐	Sensitive to biting	☐	☐
Ortho treatments (braces)	☐	☐	Food impaction	☐	☐
Biting cheeks/lips	☐	☐	Clenching	☐	☐
Clicking/popping jaw	☐	☐	Bruxing	☐	☐
Difficulty opening or closing jaw	☐	☐	Shifting of teeth	☐	☐
Mouth breather	☐	☐	Change in bite	☐	☐

ORAL HYGIENE

Do you use the following?	YES	NO
Brush	☐	☐
Dental floss	☐	☐
Fluoride rinse	☐	☐
Nightguard	☐	☐
Other _____		

How often do you brush _____

Brush is: Soft ☐ Medium ☐ Hard ☐

To the best of my knowledge, all of the preceding answers are true and correct.

If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.

Signature of Patient
Parent, or Guardian _____ Date _____