

MICHAEL R. BOLDT, D.M.D.
Health Questionnaire
For your health's sake you must be accurate

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex M F

Physicians Name \_\_\_\_\_ Physicians Phone Number \_\_\_\_\_

Answers to the following questions are for our records only and will be considered confidential. Please answer all questions by marking the appropriate box.

- 1. Are you having any pain or discomfort at this time?
2. Are you dissatisfied with the appearance of your teeth or smile?
3. Do you feel very nervous about receiving dental treatment?
4. Have you ever had a bad experience in the dental office?
5. Have you been a patient in the hospital during the past two years?
6. Have you been under care of a physician during the past two years?
7. Are you taking any medications at this time? if so, what?

- 8. Have you ever had excessive bleeding requiring special treatment?
9. Are you allergic to, or had an unusual reaction to any of the following medications:

Table with 4 columns: Medication Name, Yes, No, Medication Name, Yes, No. Rows include Dental Anesthesia, Penicillin, Aspirin, Codeine, Sulfa, and Other.

- 10. Please mark any of the following which you have had or have at this time:
Heart failure, Heart disease or attack, Angina Pectoris, High blood pressure, Heart murmur, Rheumatic fever, Congenital heart lesions, Scarlet fever, Artificial heart valve, Mitral valve prolapse, Heart pacemaker, Artificial joint, Drug or alcohol abuse, Anemia, Stroke, Kidney trouble, Ulcers, Emphysema, Chronic bronchitis, Chronic cough, Tuberculosis, Asthma, Hay fever, Sinus troubles, Allergies or hives, Excessive nervousness, Diabetes, Thyroid disease, Radiation or cobalt treatment, Chemotherapy (cancer), Arthritis, Rheumatism, Cortisone medicine, Glaucoma, Pain in Jaw Joint, Difficulty opening mouth wide, Difficulty chewing food, Difficulty swallowing, Injury to face or jaw, AIDS or HIV positive, Hepatitis A (infectious), Hepatitis B (serum), Liver disease, Yellow jaundice, Blood transfusion, Hemophilia, Venereal disease, Cold sores, Epilepsy or seizure, Fainting or dizziness, Bruise easily

- 11. Do you use any type of tobacco at this time?
12. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired?
13. Do your ankles swell during the day?
14. Have you lost or gained more than 10 lbs. in the past year?
15. Are you on a special diet?
16. Has your physician ever said you have cancer or a tumor?
17. Do you have any other disease, condition or problem not listed?
18. WOMEN: Are you pregnant now? Do you anticipate becoming pregnant?

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