EXAMINATION QUESTIONNAIRE (Please print)

Client Name:_____**Date:**_____
Date of Birth:_____ **Sex:** _____ **Height:**_____ **Weight:**_____
Referring Case Manager's Name:_____ **Phone:**_____
CSB:_____ **Case Manager's email address:**_____
Is Client COOPERATIVE or UNCOOPERATIVE for dental services? (Please circle one)_____
Residential Provider: _____**Contact:**_____**Phone:**_____
Residential Address:_____ **City:**_____**Zip:**_____
Guardian/LAR/AR:_____**Phone:**_____

In the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

1. **Has there been any change in your general health within the past years?..... Yes No**
2. **My last physical examination was on**_____
3. **Are you now under the care of a physician?..... Yes No**
   If so, what is the condition being treated_____
4. **The name and address of my physician(s) is**_____
   _____
   _____
5. **Have you had any serious illness, operation, or been hospitalized in the past 5 years?..... Yes No**
   If so, what was the illness or problem?_____
6. **Are you taking any medicine(s) including non-prescription medicine?..... Yes No**
   If so, what medicine(s) are you taking?_____
   _____
   _____
   _____
   _____
   _____

7. **Do you have or have you had any of the following diseases or problems?**
   a. **Damaged heart valves or artificial valves, including heart murmur or rheumatic heart disease…. Yes No**
   b. **Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)…….. Yes No**
      1. **Do you have chest pain upon exertion?..... Yes No**
      2. **Are you ever short of breath after mild exercise or when lying down?..... Yes No**
      3. **Do your ankles swell?..... Yes No**
      4. **Do you have inborn heart defects?..... Yes No**
      5. **Do you have a cardiac pacemaker?.....Yes No**
   c. **Allergy…… Yes No**
   d. **Sinus trouble…….... Yes No**
   e. **Asthma or hay fever……..... Yes No**
   f. **Fainting spells or seizures……... Yes No**
   h. **Diabetes…… Yes No**
   i. **Hepatitis, jaundice, or liver disease…… Yes No**
   j. **AIDS or HIV infection…… Yes No**
   k. **Thyroid problems…… Yes No**
   l. **Respiratory problems, emphysema, bronchitis, etc…… Yes No**
   m. **Sleep apnea…… Yes No**
   n. **Arthritis or painful swollen joints……... Yes No**
   o. **Stomach ulcer or hyperacidity…….. Yes No**
   p. **Kidney trouble……Yes No**
   q. **Tuberculosis……Yes No**
   r. **Persistent cough or cough that produces blood…… Yes No**
   s. **Persistent swollen glands in neck……... Yes No**
   t. **Low blood pressure…….. Yes No**

EXAMINATION QUESTIONNAIRE (Please print)

u. Sexually transmitted disease…… Yes No
v. Epilepsy or other neurological disease…… Yes No
w. Problems with mental health…… Yes No
x. Cancer…… Yes No
y. Problems of the immune system…….. Yes No

8. Have you had abnormal bleeding?..... Yes No
   a. Have you ever required a blood transfusion:…… Yes No
9. Do you have any blood disorder such as anemia?..... Yes No
10. Have you ever had any treatment for a tumor or growth?..... Yes No
11. Are you allergic or have you had a reaction to:
   a. local anesthetics…….. Yes No
   b. Penicillin or other antibiotics…… Yes No
   c. Sulfa drugs…….. Yes No
   d. Barbiturates, sedatives or sleeping pills……... Yes No
   e. Aspirin…… Yes No
   f. Iodine…… Yes No
   g. Codeine or other narcotics…… Yes No
   h. Other…… Yes No
12. Have you had any serious trouble associated with any previous dental treatment?..... Yes No
   If so, explain:_____
   _____
13. Do you have any disease, condition, or problem not listed above that you think I should know about?..... Yes No
   If so, explain:_____
   _____
14. Are you wearing contact lenses?..... Yes No
15. Are you wearing removable dental appliances?..... Yes No
16. What is your chief dental complaint?_____
_____

Women:

17. Are you pregnant?..... Yes No
18. Do you have any problems associated with your menstrual period?..... Yes No
19. Are you nursing?..... Yes No
20. Are you taking birth control pills?..... Yes No

_____

THIS TWO PAGE FORM MUST BE FILLED OUT ENTIRELY WITH NO QUESTIONS LEFT BLANK. A COMPLETE LIST OF CURRENT MEDICATIONS (PRESCRIPTION AND NON-PRESCRIPTION) MUST BE PROVIDED.

I certify that I have read and understood the above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold my dentist or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____
Signature of Client or Authorized Representative/Legal Guardian Date

_____ _____
Signature of Dentist Date

_____ _____
Signature of Anesthesiologist Date

Notes/updates:_____
_____