NEIL R WOODS, DDS
HEALTH QUESTIONNAIRE

Date_____

Name_____ Address_____
Last First Middle Number and Street

City State Zip Code Home Phone Cell Phone E-Mail Business Phone

Date of Birth Social Security No. Sex Marital Status Height Weight Occupation

Spouse's Name Closest Relative Phone No

If you are completing this form for another person, what is your relationship to that person?_____

In the following questions, circle YES or NO, whichever applies. Your answers are for your records only and will be considered confidential.

1. Has there been any change in your general health within the past year? ..... YES NO
2. My last physical was on_____
3. Are you now under the care of a physician? ..... YES NO
   If so, what condition is being treated?_____
4. Physician's name, address, phone: _____
   _____
   _____
5. Have you ever had any serious illness or operation? ..... YES NO
6. Have you had any serious illness within the past five (5) years? ..... YES NO
   If so, what?_____
7. Do you have, or have you had any of the following diseases or problems:
   (a) Rheumatic fever or rheumatic heart disease? ..... YES NO
   (b) Congenital heart lesions? ..... YES NO
   (c) Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)? ..... YES NO
      i. Do you have pain in the chest upon exertion? ..... YES NO
      ii. Are you ever short of breath after mild exercise? ..... YES NO
      iii. Do your ankles swell? ..... YES NO
      iv. Are you ever short of breath when you lie down, or do you require extra pillows when you sleep? ..... YES NO
   (d) Allergy ..... YES NO
   (e) Sinus trouble ..... YES NO
   (f) Asthma or hay fever ..... YES NO
   (g) Hives or skin rash ..... YES NO
   (h) Fainting spells or seizures ..... YES NO
   (i) Diabetes ..... YES NO
      i. Do you have to urinate (pass water) more than six (6) times a day? ..... YES NO
      ii. Are you thirsty much of time? ..... YES NO
      iii. Does your mouth frequently feel dry? ..... YES NO
   (j) Hepatitis, jaundice or liver disease? ..... YES NO
   (k) Arthritis? ..... YES NO
   (l) Inflammatory rheumatism (painful swollen joints)? ..... YES NO
   (m) Stomach ulcers? ..... YES NO
   (n) Kidney trouble? ..... YES NO
   (o) Tuberculosis? ..... YES NO
   (p) Do you have a persistent cough or do you cough up blood? ..... YES NO
   (q) Low blood pressure? ..... YES NO
   (r) Venereal disease? ..... YES NO
   (s) Have you tested HIV positive or been diagnosed with AIDS? ..... YES NO
8. Have you had abnormal bleeding associated with pervious extractions, surgery or trauma? ..... YES NO

9. Do you have any kind of blood disorder such as anemia? ..... YES NO
10. Have you had surgery or x-ray treatment for a tumor, growth or other condition of your mouth or lips? ..... YES NO
11. Are you taking any drug or medicine? ..... YES NO

If so, what? _____

_____

12. Are you taking any of the following?

(a).	Antibiotics or sulfa drugs?	YES	NO
(b)	Anticoagulants (blood thinners)?	YES	NO
(c)	Medicine for high blood pressure?	YES	NO
(d)	Cortisone (steroids)	YES	NO
(e)	Tranquilizers?	YES	NO
(f)	Antihistamines?	YES	NO
(g)	Aspirin?	YES	NO
(h)	Insulin, tolbutamide (Orinase) or similar drug?	YES	NO
(i)	Digitalis or drugs for heart trouble?	YES	NO
(j)	Nitroglycerin?	YES	NO
(k)	Other?	YES	NO

13. Are you allergic or have your reacted adversely to:

(a)	Local anesthetics?	YES	NO
(b)	Penicillin or other antibiotics?	YES	NO
(c)	Sulfa drugs?	YES	NO
(d)	Barbituates, sedatives, or sleeping pills?	YES	NO
(e)	Aspirin?	YES	NO
(f)	Iodine?	YES	NO
(g)	Codeine or other narcotics?	YES	NO
(h)	Other? _____		

14. Have you had any serous trouble associated with any pervious dental treatment? ..... YES NO

If so, explain: _____

_____

15. Do you have any disease, condition or problem not listed above that you think I should know about? ..... YES NO

If so, explain: _____

_____

16. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation? ..... YES NO
17. Are you wearing contact lenses? ..... YES NO
18. Do you have AIDS? ..... YES NO
19. Are you HIV positive? ..... YES NO
20. Are you pregnant? ..... YES NO
21. Do you have any problems related to menstruation? ..... YES NO

For your further comfort, would you be interested in sedation dentistry? ..... YES NO

22. Do you feel sleepy during the day, even when you get a good night's sleep? ..... YES NO
23. Do you get very irritable when you can't sleep? ..... YES NO
24. Do you often wake up at night and have trouble falling back to sleep? ..... YES NO
25. Does it usually take you a long time to fall asleep? ..... YES NO
26. Do you often wake up very early and find that you cannot fall back to sleep? ..... YES NO
27. Do you usually feel achy and stiff when you wake up in the morning? ..... YES NO
29. Do you sometimes wake up gasping for breath? ..... YES NO
30. Does your bed partner say that your snoring keeps him/her from sleeping? ..... YES NO
31. Have you ever fallen asleep driving? ..... YES NO

_____

Patient/Guardian Signature