MEDICAL HEALTH QUESTIONNAIRE FOR STEVEN N. KACEL, D.D.S. , P.C.

Date:_____

Name_____ **Email**_____

Last First Middle

Address_____City_____State_____Zip_____

Cell Phone_____Home Phone_____Work Phone_____

Please circle the Preferred Daytime Phone Number for the office to reach you.

Date of Birth_____Social Security No._____ Sex_____Height_____Weight_____

Single_____Married_____Divorced_____Widowed_____Separated_____ Occupation_____ _____

Spouse or Parent's/Guardian's Name_____Employer_____ _____

Person to Contact in case of an emergency_____Phone_____ _____

How were you referred to our office?_____ _____

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

Has there been any change in your general health within the past year?_____ **Yes** **No**

Your last physical examination was on_____

Are you under the care of a physician?_____ **Yes** **No**

If so, what is the condition being treated?_____

Name, address and phone # of your physician_____

Have you had any serious illnesses, operations or been hospitalized in the past 5 years?_____ **Yes** **No**

If so, what was the illness or problem?_____

Do you have or have you had any of the following diseases or problems?

Damaged heart valves, including heart murmur or rheumatic heart disease_____ **Yes** **No**

Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, 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. Mitral Valve Prolapse_____ **Yes** **No**

Cardiac pacemaker?_____ **Yes** **No**

Sinus trouble?_____ **Yes** **No**

Asthma or hay fever?_____ **Yes** **No**

Fainting spells or seizures?_____ **Yes** **No**

Persistent diarrhea or recent weight loss?_____ **Yes** **No**

Diabetes?_____ **Yes** **No**

Eating Disorders?_____ **Yes** **No**

Hepatitis, jaundice or liver disease?_____ **Yes** **No**

AIDS or HIV infection?_____ **Yes** **No**

Thyroid problems?_____ **Yes** **No**

Respiratory problems, emphysema, bronchitis, etc…_____ **Yes** **No**

Arthritis or painful swollen joints?_____ **Yes** **No**

Stomach ulcer or hyperacidity?_____ **Yes** **No**

Kidney trouble?_____ **Yes** **No**

Tuberculosis?_____ **Yes** **No**

Persistent cough or cough that produces blood?_____ **Yes** **No**

Tattoo's?_____ **Yes** **No**

High or low blood pressure?_____ **Yes** **No**

Sexually transmitted disease?_____ **Yes** **No**

Epilepsy or other neurological disease?_____ **Yes** **No**

Problems with mental health?_____ **Yes** **No**

Cancer?_____ **Yes** **No**

Problems of the immune system?_____ **Yes** **No**

Have you had abnormal bleeding?_____ **Yes** **No**

Have you ever required a blood transfusion?_____ **Yes** **No**

Do you have any blood disorder such as anemia?_____ **Yes** **No**

Have you ever had any treatment for a tumor or growth?_____ **Yes** **No**

Are you taking any drug or medicine such as any of the following:

Antibiotics or sulfa drugs **Yes No**		Aspirin	**Yes** **No**
Anticoagulants (blood thinners) **Yes No**		Insulin, tolbutamide (orinase) or similar (	**Yes** **No**
Medicine for high blood pressure **Yes No**		Digitalis or medication for heart trouble	**Yes** **No**
Cortisone (steroids) **Yes No**		Nitroglycerin	**Yes** **No**
Tranquilizers **Yes No**		Antihistamines	**Yes** **No**

Other_____

Are you allergic or have you reacted adversely to:

Local anesthetics **Yes No**		Aspirin	**Yes** **No**
Penicillin or other antibiotics **Yes No**		Codeine or other narcotics	**Yes** **No**
Barbituates, sedatives, sleeping pills **Yes No**		Other_____	**Yes** **No**

Do you have any disease, condition, or problem not listed above that you think I should know about?_____ **Yes** **No**

If so, explain_____

Do you wear contact lenses?_____ **Yes** **No**

Chemical Dependency?_____ **Yes** **No**

If yes, explain_____ **Yes** **No**

Do you use Tobacco? **Yes** **No** How much?_____

Do you consume alcohol on a daily basis? **Yes** **No** How much?_____

Women: Are you pregnant? **Yes No** Do you have any problems associated with your menstrual cycle? **Yes** **No**

Are you nursing? **Yes No** Are you taking birth control pills? **Yes No** _____

If you could change **ANYTHING** about your smile, what would you change?_____ _____

Have you had any serious trouble associated with any previous dental treatment?_____ **Yes** **No**

If so, explain_____

Have you ever had treatment for your gums? **Yes No** What type of treatment?_____

Have you ever had orthodontic treatment? **Yes No** When? _____

How often do you visit the dentist?_____When was your last visit to the dentist?_____

Are your teeth sensitive to: Heat____Cold____Sweets____Pressure____Do you have bleeding gums? **Yes____ No____**

Do you have frequent canker sores or cold sores? **Yes No** Does your jaw click when you chew? **Yes No**

Does your food pack between your teeth? **Yes No** If yes, where?_____

Do you have any sores or lumps in your mouth?_____

How many times per day do you brush your teeth?_____Do you ever clench or grind your teeth? **Yes No**

What is the reason for this dental visit?_____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and treatment or examination rendered to me or my child during the period of such dental care to third party payers and or health practitioners. I authorize and request my insurance company to pay directly to the dental group. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

Signature of Patient or Parent or Guardian_____Date_____