James A. Snyder and Associates
5284 Dawes Avenue, Alexandria, VA 22311

HEALTH QUESTIONNAIRE

NAME_____ AGE_____ DOB_____ HEIGHT_____ WEIGHT_____ DATE_____
PHYSICIAN_____ PHYSICIAN'S PHONE #_____
DATE OF LAST PHYSICAL EXAM AND RESULTS_____

We welcome the opportunity to provide your dental/anesthesia care. To provide maximum safety and efficiency we ask that you provide accurate answers to the questions relating to your general state of health.
Thank you for your help, we look forward to caring for you.
PLEASE WRITE ANY ADDITIONAL COMMENTS IN THE SPACE TO THE RIGHT
ONLY MARK IF THE RESPONSE IS YES

PRESENT HEALTH:
___ Are you in good health
___ Under the care of a physician in last two years
___ Presently taking any medications / herbal remedies (Please List)
___ Have you ever taken steroids?___when?____for how long?_____
___ Do you take any blood thinners
___ Please list current medications
___ Have you ever taken any Diet pills (Phen Fen)

MEDICATIONS (PLEASE LIST)
_____
_____
_____
_____
_____
_____

ALLERGIES:
Are you allergic to any medications such as:
___ Aspirin, Novocaine, Penicillin, Antibiotics, Codiene
___ Are you sensitive or allergic to latex or any jewelery

ALLERGIES (PLEASE LIST)
_____
_____
_____
_____
_____
_____

PAST ILLNESS, OPERATIONS:
___ Any major operations What and When_____
___ Any serious illnesses What and When_____
___ Any Hospitalizations What and when_____

CARDIOVASCULAR:
___ Any heart problems, or heart surgery
___ Bacterial Endocarditis
___ Rheumatic Fever or Rheumatic Heart Disease
___ Heart Murmur or Mitral Valve Prolapse
___ Congestive Heart Failure
___ Angina, Swollen Ankles or short of breath easily
___ Pacemaker
___ High or low blood pressure

HEART PROBLEMS (PLEASE LIST)
_____
_____
_____

OTHER INFORMATION
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

RESPIRATORY:
___ Do you have Asthma?
___ Emphysema, Bronchitis, Pneumonia or other lung disease
___ Do you smoke?____ How many packs per day____ years____
___ Exposed to or had Tuberculosis

BLOOD:
___ Anemia
___ Abnormal bleeding from dental extraction or a cut
___ Bruise easily
___ HIV or ARC
___ Leukemia
___ Sickle Cell Disease or Trait

ENDOCRINE:
___Diabetes or family history of Diabetes
___Over or under active Thyroid
___Goiter
___Other Glandular disorder

NERVOUS SYSTEM:
___ Epilepsy or Seizures, and last occurence _____
___Severe or frequent headaches or face pain
___Excessive sweating or trembling
___Nervous breakdown
___Excessive nervousness
___Ever under psychiatrists care
___Stroke

GI AND GU:
___Reflux, Hiatal Hernia or Heartburn
___Stomache problems or ulcers
___Liver, Gall Bladder problems, or Hepatitis
___Kidney or urinary problems

FEMALES:
___Are you or could you be pregnant now?
___Problems with menstrual cycle
___Are you nursing?
___Do you take Birth Control Pills?

OTHER:
___Glaucoma
___Sinus trouble
___Skin disease
___Arthritis or Rheumatism
___Recent gain or loss of weight
___Fever Blisters or Canker Sores
___Herpes, Syphilis, Gonnorrhea, Venereal Disease
___Radiation or Radioactive Isotope treatment
___Tumor or cancer
___Artificial joints or prosthesis
___Have you ever had general____ or local anesthesia?____
___History of recreational drug use

DENTAL:
___Cold or Hot sensitive teeth
___Bleeding gums
___Bad taste or odor in mouth
___Frequent gum infections
___Gum surgery
___Jaw or muscle pain when opening or closing mouth
___Clicks or pops of jaw joint
___Clenching or grinding of teeth
___Orthodontics or braces

ANY ADDITIONAL COMMENTS

SIGNATURE_____ DATE_____