HEALTH QUESTIONNAIRE

Esteban Mulkay. D.M.D.

Last name: (print) _____ Date: _____

First name: _____ Title: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.

Date of birth: _____ Marital status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Street: _____ City:_____ Zip code: _____

Social security #: _____-_____-_____ Email: _____

Home phone:_____ Cell phone: _____ Business phone: _____

Best phone number to reach you: ☐ Home ☐ Cell ☐ Business

Employed by: _____ Spouse's name: _____ Spouse's work phone: _____

Spouse employed by: _____ Nearest relative: _____ Phone: _____

Referred by: _____

	Yes	No
1. Are you under a physician's care at present?	☐	☐
2. Do you have any type of health problem?	☐	☐
If yes, if yes please specify		
_____		
_____		
3. Are you taking any medicine or vitamins now?	☐	☐
If yes, please list all:		
_____		
_____		
4. Have you ever been seriously ill?	☐	☐
5. Do you have any of the following?		
A heart valve replacement	☐	☐
A history of infective endocarditis (IE)	☐	☐
A serious congenital heart condition	☐	☐
Heart trouble	☐	☐
Diabetes	☐	☐
Positive HIV or AIDS	☐	☐
A joint replacement (hip, knee, etc.)	☐	☐
Hepatitis	☐	☐
Venereal disease	☐	☐
Herpes	☐	☐
Stroke	☐	☐
High blood pressure	☐	☐
Anemia	☐	☐
6. Have you ever had an allergic reaction to any of the following?		
Aspirin	☐	☐
Penicillin	☐	☐
Tetracycline	☐	☐
Other medicine: _____	☐	☐

(over)

	Yes	No
7. Have you ever experienced an unusual reaction to a dental injection (novocaine)?	☐	☐
8. Have you ever had an injury to your face or jaws?	☐	☐
9. Have you ever had surgery for a tumor, growth or skin disease?	☐	☐
10. Have you ever had radiation treatment?	☐	☐
11. Are you short of breath on mild exertion?	☐	☐
12. Do you have chest pain on exertion?	☐	☐
13. Do your ankles swell?	☐	☐
14. Have your ever had prolonged bleeding following a cut or extraction of a tooth?	☐	☐
15. Do you smoke cigarettes?	☐	☐

If **yes**: How many packs/day: _____

How many years have you smoked? _____

16. Do you smoke cigars or a pipe?	☐	☐
17. How may times per week do you drink alcohol? _____		
18 Do you have any disease, condition or problem not listed above that you think I should know about?	☐	☐

If yes, please specify _____

_____

19. Is there anything that you would like to discuss with the doctor in *private*?	☐	☐
20. Are you presently in a relationship with a person who threatens you or physically hurts you?	☐	☐

Women only

21. Do you have osteoporosis?	☐	☐
22. Do you take any medication for osteoporosis?	☐	☐
23. Have you reached menopause?	☐	☐

Physician (Medical doctor)

Name: _____

Address: _____

_____

Date of last physical exam: _____

Findings: _____

_____

Signature: _____ Date: _____

(patient or relative representative)