Health Questionnaire

Craig Timberlake DDS, Scott Shaw DDS
4522 15th Avenue NE, Seattle Washington 98105
Phone: (206) 523-2025 Fax: (206) 525-6956 Email: info@timberlakeshawdds.com

Medical History

Do you have (or have you ever had) any of the following?

Yes No 1. Allergic reaction to drugs or latex? (circle below)
Latex Penicillin Aspirin Codeine Local Anesthetics Metal
Other: _____

Yes No 2. Heart attack or heart disease
Yes No 3. Stroke
Yes No 4. High blood pressure
Yes No 5. Congestive heart failure
Yes No 6. Angina (chest pains)
Yes No 7. Irregular heartbeat (arrhythmia)
Yes No 8. Artificial heart valve
Yes No 9. Rheumatic fever, Rheumatic heart disease
Yes No 10. Bacterial Endocarditis (SBE)
Yes No 11. Congenital heart disease
Yes No 12. Heart murmur or Mitral Valve Prolapse
Yes No 13. Immunosuppressive condition (circle below)
Steroid Therapy (e.g. prednisone) Radiation Therapy Chemotherapy HIV
SLE (Lupus) Rheumatoid Arthritis Organ Transplant Spleen Removed
Other: _____

Yes No 14. Artificial joints (circle below)
Hip Knee Ankle Shoulder
Other: _____ Date placed: _____

Yes No 15. Other artificial implants or devices (e.g. pacemaker)
Yes No 16. Bleeding problem, anemia, other blood disease
Yes No 17. Diabetes (circle) Type I or Type II
Yes No 18. Thyroid disease
Yes No 19. Nervous system disease or seizures
Yes No 20. Stomach or intestinal disease
Yes No 21. Kidney disease
Yes No 22. Hepatitis (circle) A, B, C, or D
Yes No 23. Other liver disease: _____
Yes No 24. Arthritis (osteo or rheumatoid)
Yes No 25. Other muscle or joint disease: _____
Yes No 26. Asthma
Yes No 27. Tuberculosis
Yes No 28. Other lung disease: _____
Yes No 29. Mental health condition
Specify: _____
Yes No 30. Physical or mental disabilities that may require special care
Yes No 31. Do you have or have you ever been treated for cancer?
Yes No 32. Are you or could you be pregnant?
Yes No 33. Are you nursing?
Yes No 34. Do you have any disease, condition or problem not listed here?
Describe: _____

Yes No 35. Have you ever been hospitalized or had surgery?

Describe: _____

Yes No 36. Are you currently or have you ever had a history of addiction?
(e.g. alcohol, prescription drugs, illicit drugs, etc)

Yes No 37. Do you smoke or use tobacco products? If yes how often? _____

Yes No 38. Are you a past user of tobacco products?

Yes No 39. Have you undergone current or past osteoporosis therapy?
(e.g. Fosamax, Actonel, Boniva)

Yes No 40. Have you undergone current or past therapy to reduce high blood calcium (aka bisphosphonate therapy)? (e.g. IV Aredia, Zometa)

Yes No 41. Do you regularly take herbal medicines or dietary supplements? (circle below)
Echinacea Garlic Ginger Kava Valerian Feverfew Gingko Ginseng
St. John's Wort Vitamin E Other: _____

Yes No 42. Are you currently taking any medications? If yes, please list below

_____

Primary Care Physician

Name Address City Phone #

_____

Dental History

Chief complaint: (why are you seeking dental care?) _____

Yes No 1. When was your last dental exam? _____

Yes No 2. Have you had any issues with past dental treatment?
If so, please explain: _____

Yes No 3. Do your gums often bleed when you brush or floss?

Yes No 4. Have you ever had orthodontic treatment (braces)?

Yes No 5. Have you ever been treated for Periodontal Disease? (gum disease)

Yes No 6. Have you noticed any lumps or sores in your mouth?

Yes No 7. Have you ever suffered a traumatic injury to your face, jaws, mouth or teeth?

Yes No 8. Are you allergic to any dental materials?

Yes No 9. Has fear ever prevented you from seeking dental treatment?

Yes No 10. Are you unhappy with the appearance of your teeth?

Yes No 11. Is there anything you would like to change about your smile?

Authorization and Release

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 inaccurate information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any 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 dentist any dental group insurance benefits otherwise payable to me. 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 behalf of myself or my dependents.

X _____ Date: _____

Signature of patient or parent/guardian if patient is a minor

Health History Updates:

Date: _____ Changes: _____ Initials: _____

_____ _____ _____