DR. ALLAN FINKLEMAN

DR. ALEX ZIMMER

HEALTH QUESTIONNAIRE

Patient's Name	Medical Doctor's Name
Date of Birth Age	Medical Doctor's Phone #
Pharmacy, if applicable	Date of Last Medical Visit / Blood Pressure

Do you have, or have you ever had, any of THE FOLLOWING CONDITIONS?

☐ Acid Reflux Disease	☐ Diabetes (1 or 2)	☐ Immune Disorders	☐ Mitral Valve Prolapse
☐ AIDS/HIV Infection	☐ Drug/Alcohol Dependency	☐ Infective Endocarditis	☐ Neck/Back Problems
☐ Alzheimer's Disease	☐ Epilepsy/Seizures	☐ Injury to Face/Jaw	☐ Neurological Disorders
☐ Angina/Chest Pain	☐ Fainting	☐ Joint Replacement	☐ Organ Transplant
☐ Anorexia/Bulimia	☐ Gastro-Intestinal Disease	☐ Kidney Disease	☐ Radiation/Chemotherapy
☐ Arthritis	☐ Heart Attack	☐ Liver Disease/Jaundice	☐ Rheumatic Heart Disease
☐ Asthma	☐ Heart Murmur	☐ Loss of Eyesight	☐ Sinus Trouble
☐ Blood Disorders	☐ Heart Pacemaker	☐ Loss of Hearing	☐ Stroke
☐ Blood Pressure (High or Low)	☐ Heart Valve Condition	☐ Lung Disease	☐ Thyroid Problems
☐ Cancer/Tumours	☐ Heart - Other	☐ Lupus	☐ Tuberculosis
☐ Cold Sores/Cankers	☐ Hepatitis (A, B, C, D, E)	☐ Malignant Hyperthermia	☐ Venereal Disease
☐ Congenital Heart Disease	☐ High Cholesterol	☐ Mental Health Problems	☐ * NONE OF THE ABOVE *

☐ Other Illnesses or Surgeries - Please Explain:	☐ Concerns with Dental Treatment - Please Explain:

MEDICATIONS (Including over-the-counter drugs, vitamins, and herbal supplements, etc.)

1	2	3	4
5	6	7	☐ See attached Medication List

ALLERGIC REACTIONS / ADVERSE EFFECTS

☐ Anesthetics	☐ Latex	☐ Penicillin	☐ Other:
☐ Codeine	☐ Metals	☐ Sulfa Drugs	☐ * NO KNOWN ALLERGIES *

SMOKING STATUS

☐ Non-Smoker

☐ Previous Smoker: From To

☐ Smoker: Since #/Day

WOMEN ONLY – ARE YOU PREGNANT?

☐ Yes - Due Date: ☐ No

GENERAL RELEASE

To the best of my knowledge, the questions on this form have been accurately and completely answered. I will not hold my dentist or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form. I acknowledge that it is my responsibility to inform my dental office of any changes in my health status and/or medications.

Signature of Patient (or Guardian)

Date

STAFF NOTES

☐ INR Level Required (2.0 to 3.0) ☐ Prophylactic Antibiotics Required Signature of Dentist/Staff