DENTAL HEALTH QUESTIONNAIRE

Personal Data - Privacy Act of 1974

BUMEDINST 6600.12

My chief complaint or Reason for this Examination is: _____

HAVE YOU EVER HAD OR HAVE YOU NOW: *(Please check at the Right of each item)*

(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW
Epilepsy or Seizures				Hemophilia				Ulcers			
Fainting or Dizziness				Bruise or Bleed easily				Kidney problems			
Nervousness				Heart problems or Angina				Veneral disease			
Stroke				Hypertension				Diabetes			
Glaucoma				Rheumatic fever				Thyroid disease			
Cold sores (Herpes)				Heart murmur				HIV +			
Persistent cough				Mitral valve prolapse				Arthritis			
Emphysema				Congenital heart lesions				Painful joints (incl. jaw)			
Tuberculosis/PPD positive				Heart surgery				Prosthetic joint(s)			
Asthma				Prosthetic heart valve(s)				Hives			
Hay fever				Pacemaker				Steroid medication(s)			
Sinus problems				Blood transfusion(s)				Drug addiction			
Anemia				Liver disease				Alcoholism			
Sickle cell disease				Yellow jaundice				Unexplained weight change			
G-6PD deficiency				Hepatitis - type:				Cancer/radiation			

1. Have you ever been told that you should not donate blood? _____
2. Have you ever been told that you need antibiotics before dental treatment? _____
3. Females: Are you taking birth control pills (BCPs)? _____
   Are you or might you be pregnant? (Estimated delivery) _____
   Are you breast feeding at the present time? _____
4. Do you have a disease, condition, or problem not listed above? _____

If yes, Please Describe: _____

INSTRUCTIONS: Please answer the following questions by circling, and if applicable by entering the appropriate response: If yes, describe - If no, please write "no/none"

1. **Are You In: Flight Status . . Yes No / Personnel Reliability Program?**
2. **Are You Presently Ill Or Under The Care Of A Physician** **YES NO**

If Yes, Please Describe: _____

History Of Hospitalizations: _____
(Including Cancer Treatment) _____

3. **Any Allergies?** (Including Rubber) _____
4. **Medications Presently Taking:** _____
(including aspirin, etc.) _____

Any Family History Of: (Circle)
Heart Disease Cancer
Diabetes Seizures

Your Social History:
- Type and frequency of:
- Tobacco use: (age started?)
- Alcohol consumption:

Occupation/Jobs: _____

Patient's Signature	Date	Dental Officer's Signature	Date
Patient's Signature	Date	Dental Officer's Signature	Date
Patient's Signature	Date	Dental Officer's Signature	Date
Patient's Signature	Date	Dental Officer's Signature	Date

SUMMARY OF PERTINENT FINDINGS/RECOMMENDED TREATMENT MODIFICATIONS: *(Dentist's use only)*

PATIENT'S IDENTIFICATION *(Use Space for Mechanical Imprint)*

Patient's Name (*Last, First, Middle initial*)			SEX
DATE OF BIRTH	RELATIONSHIP TO SPONSOR	COMPONENT/STATUS	DEPART/SERVICE
SPONSOR'S NAME			Rank/Grade
SSN OR IDENTIFICATION NO.		ORGANIZATION	