Health History Questionnaire

**Please be sure to keep scrolling until you reach the end of the questionnaire.*

1. **Abnormal Bleeding**
   - Yes
   - No

2. **Alcohol/Drug Abuse**
   - Yes
   - No

3. **Anemia**
   - Yes
   - No

4. **Arthritis**
   - Yes
   - No

5. **Artificial Bones/Joints/Valves**
   - Yes
   - No

6. **Asthma**
   - Yes
   - No

7. **Blood Transfusion**
   - Yes
   - No

8. **Cancer/Chemotherapy**
   - Yes
   - No

9. **Colitis**
    - Yes
    - No

10. **Congenital Heart Defect**
    - Yes
    - No

11. **Diabetes**
    - Yes
    - No

12. **Difficulty Breathing**
    - Yes
    - No

13. **Emphysema**
    - Yes
    - No

14. **Epilepsy**
    - Yes
    - No

15. **Fainting Spells**
    - Yes
    - No

16. **Frequent Headaches**
    - Yes
    - No

17. **Glaucoma**
    - Yes
    - No

18. **Hay Fever**
    - Yes
    - No

19. **Heart Attack**
    - Yes
    - No

20. **Heart Murmur**
    - Yes
    - No

21. **Heart Surgery**
    - Yes
    - No

22. **Hemophilia**
    - Yes
    - No

23. **Hepatitis**
    - Yes
    - No

24. **Herpes/Fever Blisters**
    - Yes
    - No

25. **High Blood Pressure**
    - Yes
    - No

26. **HIV+/AIDS**
    - Yes
    - No

27. **Hospitalized for Any Reason? If yes, please explain:**
    - Yes
    - No

28. **Kidney Problems**
    - Yes
    - No

29. **Liver Disease**
    - Yes
    - No

30. **Low Blood Pressure**
    - Yes
    - No

31. **Mitral Valve Prolapse**
    - Yes
    - No

32. **Pacemaker**
    - Yes
    - No

33. **Psychiatric Treatment**
    - Yes
    - No

34. **Radiation Treatment**
    - Yes
    - No

35. **Rheumatic/Scarlet Fever**
    - Yes
    - No

36. **Seizures**
    - Yes
    - No

37. **Shingles**
    - Yes
    - No

38. **Sickle Cell Disease/Traits**
    - Yes
    - No

39. **Sinus Problems**
    - Yes
    - No

40. **Stroke**
    - Yes
    - No

41. **Thyroid Problems**
    - Yes
    - No

42. **Tuberculosis (TB)**
    - Yes
    - No

43. **Ulcers**
    - Yes
    - No

44. **Venereal Disease**
    - Yes
    - No

45. **Please list any other serious medical conditions not mentioned above:**

Are you allergic to any of the following?

46. **Aspirin**
    - Yes
    - No

47. **Codeine**
    - Yes
    - No

48. **Jewelry**
    - Yes
    - No

49. **Erythromycin**
    - Yes
    - No

50. **Latex**
    - Yes
    - No

51. **Dental Anesthetics**
    - Yes
    - No

52. Metals

- Yes
- No

53. Penicillin

- Yes
- No

54. Tetracycline

- Yes
- No

55. Please list any other drugs or materials that you are allergic to:

56. Are you taking any prescription, over-the-counter or supplement drugs? If yes, please list.

- Yes
- No

57. Do you require antibiotics before dental treatment? If yes, please explain below.

- Yes
- No

Questions 58 and 59 (For Women Only)

58. Are you nursing?

- Yes
- No

59. Are you pregnant?

- Yes
- No

60. Are you currently in pain?

- Yes
- No

61. Do your gums ever bleed?

- Yes
- No

62. Have you ever had a serious or difficult problem associated with any previous dental work? If yes, please explain below.

- Yes
- No

63. Do you ever experience pain or discomfort in your jaw joint?

- Yes
- No

64. Your current dental health is:

- Good
- Fair
- Poor

65. Do you like your smile?

- Yes
- No

66. **Would you like WHITER teeth?**
    - Yes
    - No

67. **Would you like FRESHER breath?**
    - Yes
    - No

68. **How many times a week do you floss?**
    - <1
    - 3-5
    - >5

69. **How many times a day do you brush?**
    - <1
    - 3-5
    - >5

70. **Types of bristles?**
    - Soft
    - Medium
    - Hard

71. **Do you smoke or use tobacco in any other form?**
    - Yes
    - No

EXISTING PATIENTS: MEDICAL HISTORY UPDATE COMPLETED

Continue

NEW PATIENTS: PLEASE CONTINUE THROUGH QUESTION 79:

Lumineer Smile Evaluation

72. Do you like the appearance of your teeth when you smile? If not, what would you change?

- ○ Yes
- ○ No

73. Are your teeth all in alignment (straight)?

- ○ Yes
- ○ No

74. Do you have spaces that you don't like? If yes, please explain:

- ○ Yes
- ○ No

75. Do you like the color of your teeth? If not, please explain:

- ○ Yes
- ○ No

76. Do you like the shape of your teeth? If not, please explain:

- ○ Yes
- ○ No

77. Are your teeth Chipped? If yes, please explain:

- Yes
- No

78. Are your teeth wearing on the biting surfaces? If yes, please explain:

- Yes
- No

79. Do you have old fillings you need to get replaced?

- Yes
- No