



# Specialty Dental Services OF GEORGIA

810 Canton Road  
Suite A  
Marietta, GA 30060  
770-428-0434

## Specialty Dental Services of GA, LLC

Dr. Richard B. Liposky  
Board Certified Oral Maxillofacial Surgeon

### Health Questionnaire

Patients Name \_\_\_\_\_ Address \_\_\_\_\_  
Last First Middle Number & Street  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_  
Place of Employment \_\_\_\_\_ Marital Status \_\_\_\_\_ Spouse Name \_\_\_\_\_  
Closest Relative \_\_\_\_\_ Phone \_\_\_\_\_  
Person Responsible for Account \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Insurance Co. \_\_\_\_\_ Policy No. \_\_\_\_\_ Group No. \_\_\_\_\_

Please circle yes or no the following questions, whichever applies. You answers are for our records only and will be kept strictly confidential.

1. Has there been any changes in your general health within the past year ..... **Yes No**
2. My last physical examination was on \_\_\_\_\_
3. Are you now under the care of a physician..... **Yes No**
  - a. For what reason \_\_\_\_\_
4. My physicians name is \_\_\_\_\_
5. Have you had any serious illness or operation ..... **Yes No**
  - a. What was the illness or operation \_\_\_\_\_
6. Have you been hospitalized or has serious illness within the past 5 years ..... **Yes No**
  - a. What was the problem \_\_\_\_\_
7. Do you or have you ever had any of the following:
  - a. Rheumatic fever or rheumatic heart disease ..... **Yes No**
  - b. Congenital heart lesions ..... **Yes No**
  - c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) ..... **Yes No**
    1. Do you have pain in your chest upon exertion ..... **Yes No**
    2. Are you ever short of breath after mild exercise ..... **Yes No**
    3. Do your ankles swell ..... **Yes No**
    4. Do you get short of breath when you lie down, or do you require extra pillows when you sleep..... **Yes No**
  - d. Allergy ..... **Yes No**
  - e. Sinus trouble ..... **Yes No**
  - f. Asthma or hay fever ..... **Yes No**
  - g. Hives or skin rash ..... **Yes No**
  - h. Fainting or dizzy spells ..... **Yes No**
  - i. Diabetes ..... **Yes No**
    1. Do you have to urinate more than 6 times a day ..... **Yes No**
    2. Are you thirsty much of the time ..... **Yes No**
    3. Does your mouth frequently become dry ..... **Yes No**
  - j. Hepatitis, jaundice or liver disease ..... **Yes No**
  - k. Arthritis ..... **Yes No**
  - l. Inflammatory rheumatism (painful swollen joints) ..... **Yes No**
  - m. Stomach ulcers ..... **Yes No**
  - n. Kidney trouble ..... **Yes No**
  - o. Tuberculosis ..... **Yes No**
  - p. Do you have a persistent cough or cough up blood ..... **Yes No**
  - q. Low blood pressure ..... **Yes No**
  - r. Venereal disease ..... **Yes No**
  - s. Do you have or have you ever had any contact with AIDS ..... **Yes No**
  - t. Other \_\_\_\_\_

8. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma ..... **Yes No**  
 a. Do you bruise easily ..... **Yes No**  
 Have you ever required a blood transfusion ..... **Yes No**  
 1. If so explain the circumstances \_\_\_\_\_
9. Do you have any blood disorder such as anemia ..... **Yes No**
10. Have you had surgery or x-ray treatment for a tumor, growth, or other condition of your mouth or lips..... **Yes No**  
 11. If so, what \_\_\_\_\_
12. Are you taking any of the following;  
 a. Antibiotics or sulfa drugs ..... **Yes No**  
 b. Anticoagulants ( Blood thinners )..... **Yes No**  
 c. Medicine for high blood pressure..... **Yes No**  
 d. Cortisone ( steroids )..... **Yes No**  
 e. Tranquilizers ..... **Yes No**  
 f. Antihistamines ..... **Yes No**  
 g. Insulin, oral med for diabetes ..... **Yes No**  
 h. Aspirin ..... **Yes No**  
 i. Digitalis or drugs for heart trouble ..... **Yes No**  
 j. Nitroglycerin ..... **Yes No**  
 k. Other \_\_\_\_\_
13. Are you allergic to or have you reacted adversely to:  
 a. Local anesthetics ..... **Yes No**  
 b. Penicillin or other antibiotics ..... **Yes No**  
 c. Sulfa Drugs ..... **Yes No**  
 d. Barbiturates, sedatives, or sleeping pills..... **Yes No**  
 e. Aspirin ..... **Yes No**  
 f. Iodine ..... **Yes No**  
 g. Codeine or other narcotics ..... **Yes No**  
 h. Other \_\_\_\_\_
14. Have you had any serious trouble associated with any previous dental treatment ..... **Yes No**  
 If so, explain \_\_\_\_\_
15. Do you have any disease, condition, or problem not listed above that you think I should know about..... **Yes No**  
 a. If so, explain \_\_\_\_\_
16. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation..... **Yes No**
17. Are you wearing contacts..... **Yes No**

**WOMEN**

18. Are you pregnant ..... **Yes No**  
 19. Do you have any problems associated with your menstrual period ..... **Yes No**

Signature of Patient \_\_\_\_\_

**For Office Use Only**

Date: \_\_\_\_ \_\_\_\_ \_\_\_\_      Allergy:                      Tobacco:              ETOH:              Age:  
 BP:                      Hosp:                      Fm HX.:  
 P:  
 R:                      Clin. Obs.  
 Temp:  
 Dx:                      Tr. Plan:                      RX:                      Refer: