Specialty Dental Services
OF GEORGIA

76 Seven Hills Boulevard
Suite 107
Dallas, GA 30132
678-574-4837

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 you 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: