Centreville Family Dentistry LLC
134 Coursevall Dr.
Centreville, Maryland 21617

Date _____
Patient # _____

HEALTH QUESTIONNAIRE

Name _____ Home Phone _____Work Phone _____
Last First Middle
Mobile Phone _____ E-mail Address _____
Address _____
St. City State Zip Code
Date of Birth _____ Age _____ Sex _____Weight _____ Single ☐ Married ☐ Spouse ☐
Occupation _____ Employer _____
Closest Relative _____ Their Telephone _____
Referred By _____
Who Will Pay This Account? _____
Name of Dental Insurance Co. _____
Policy _____ Social Security Number _____
When was your last dental appointment? _____

In the following questions, circle or highlight yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

1. Has there been any change in your general health within the past year?.....YES or NO
2. My last physical examination was on _____
3. Are you now under the care of a physician?.....YES or NO
a. If so what is the condition being treated _____
4. The name and address of my physician is _____
5. Have you had any serious illness or operation?.....YES or NO
a. If so, what was the illness or operation? _____
6. Have you been hospitalized or had a serious illness within the past five (5) years?..... YES or NO
a. If so, what was the problem? _____
7. Do you have or have you had any of the following diseases or problems
a. Cancer..... YES or NO
b. Rheumatic fever or rheumatic heart disease..... YES or NO
c. Congenital heart lesions..... YES or NO
d. Cardiovascular disease, indicate by circling (heart trouble, heart attack, coronary insufficience, coronary occlusion, high blood pressure, arteriosclerosis, stroke).....YES or NO
2) Are you ever short of breath after mild exercise .....YES or NO
3) Do your ankles swell..... YES or NO
4) Do you get short of breath when you lie down or do you require extra pillows when you sleep?.....
..... YES or NO
f. Sinus trouble.....YES or NO
g. Asthma or hay fever.....YES or NO
i. Fainting spells or seizures..... YES or NO
j. Diabetes.....YES or NO
1) Do you have to urinate (pass water) more than six times a day?..... YES or NO
2) Are you thirsty much of the time?..... YES or NO
3) Does your mouth frequently become dry?.....YES or NO
k. Hepatitis, jaundice or liver disease..... YES or NO
m. Inflammatory rheumatism (painful swollen joints).....YES or NO
n. Stomach ulcers.....YES or NO
0. Kidney trouble.....YES or NO

q. Do you have a persistent cough or cough up blood?..... YES or NO
r. Low blood pressure.....YES or NO
t. Latex allergy..... YES or NO
v. Hip replacement.....YES or NO
w. Screws or metal rods.....YES or NO
x. Heart murmur..... YES or NO
y. Stents ..... YES or NO
8. Have you had abnormal bleeding associated with previous extractions, surgery or trauma?.....YES or NO
a. Do you bruise easily?..... YES or NO
b. Have you ever required a blood transfusion?.....YES or NO
If so, explain the circumstances_____
9. Do you have any blood disorder such as anemia?.....YES or NO
10. Have you had surgery or x-ray treatment for a tumor, growth or other condition of mouth or lips?..... YES or NO
ll. Are you taking any drug or medicine?.....YES or NO
If so, what_____
12. Are you taking any of the following:
a. Antibiotics or sulfa drugs..... YES or NO
b. Anticoagulants (blood thinners)..... YES or NO
c. Medicine for high blood pressure..... YES or NO
d. Cortisone (steroids)..... YES or NO
e. Tranquilizers..... YES or NO
f. Antihistamines..... YES or NO
h. Insulin, tolbutamide (Orinase) or similar drug..... YES or NO
i. Digitalis or drugs for heart trouble..... YES or NO
j. Nitroglycerin..... YES or NO
k. Other_____
13. Are you allergic or have you reacted adversely to:
a. Local Anesthetics.....YES or NO
b. Penicillin or other antibiotic..... YES or NO
c. Sulfa drugs.....YES or NO
d. Barbiturates, sedatives or sleeping pills..... YES or NO
e. Aspirin..... YES or NO
f. Iodine.....YES or NO
g. Other..... YES or NO
14. Do you have or have you had any of the following dental conditions or problems:
a. Do you have any dental pain..... YES or NO
b. Do you have any sensitive teeth.....YES or NO
0. Do you have any difficulty in chewing your food..... YES or NO
d. Does food pack between your teeth..... YES or NO
e. Do you have bleeding gums..... YES or NO
f. Do you grind your teeth during the night..... YES or NO
g. Do you have any sores or lumps in your mouth.....YES or NO
h. Do you have any pain in or near your ears..... YES or NO
i. Have you ever had any injury to your face, jaws or teeth..... YES or NO
15. Have you had any serious trouble associated with any previous dental treatment YES or NO
If so, explain
_____
_____
_____
16. Do you have any disease, condition or problem not listed above that you think I should know about?
_____
_____
17. Are you employed in any situation which exposes you regularly to x-rays or other ionizing

radiation?..... YES or NO
18. Are you wearing contact lenses?.....YES or NO

WOMEN

19. Are you pregnant?..... YES or NO
20. Do you have any problems associated with you menstrual period?.....YES or NO

I hereby grant authority to Dr. Wolfgang Manssuri, D.D.S. and/or to the dentist in charge of my care, to administer such anesthetics; and to perform such operations as may be deemed necessary in the diagnosis and treatment of my case.

Signed _____

Signature of patient or nearest relative in the event patient is a minor or physically or mentally compromised.