HOCKLEY
FAMILY DENTISTRY

HEALTH QUESTIONNAIRE

Name _____ **Email** _____
Surname Given Name Middle

Date of Birth_____ **Parents/Guardian or Spouse** _____

Mailing Address: _____ **Tel # (hm)** _____

_____ **Tel # (cell)** _____

Civic Address: _____ **Tel # (wk)** _____

Dental Ins. Co. : _____ **Business/Company:** _____

Group/Policy # _____ **Certificate or I.D. #** _____ **Div. #** _____

Nova Scotia Health Card # _____ **Expiry date** _____

Medical Physician _____ **Tel #** _____

1. Are you being treated for any medical condition presently or have you been treated within the past 6 months?
   If so, what is the condition being treated? _____
2. Are you taking any medication at the present time?
   If so, what? _____
3. Have you ever been seriously ill?
   If so, what was the problem?
4. Have you ever had radiation therapy? (Y/N) _____ If so, when? _____
5. Any allergies to food or drugs, ect…?
   If so, what? _____
6. Have you ever had a joint replacement? (Y/N) _____ If so, when? _____
7. Women: Are you pregnant at the present time? (Y/N) _____ Due Date _____
8. Do you have or have you ever had any of the following?

	Yes	No		Yes	No
Diabetes			Pacemaker		
Jaundice			Thyroid condition		
Severe sore mouth			Tuberculosis		
Asthma			Heart Attack		
Hay Fever			Stroke		
Hives			Heart murmur		
Hepatitis			High blood pressure		
Sinus trouble			Chest pain		
Liver trouble			Shortness of breath		
Reaction to local anaesthetic			Rheumatic fever		
Arthritis			Epilepsy		
Prolonged bleeding after cut.			Kidney disorders		
Psychological disorders			Stomach ulcers		
HIV positive			Osteoporosis		

SIGNATURE _____ **DATE** _____