Michael C. Stypula, D.D.S.,M.D.S. 2555 Washington Road, Suite 621 Upper St. Clair, PA 15241 412.833.5110

Name_____Street Address_____City_____

State_____Zip Code_____Home Phone_____Social Security_____

Date of Birth_____Sex_____Height_____Weight_____Occupation_____

Employer_____Work Phone_____Marital Status_____

Spouse_____Closest Relative_____Phone_____Date_____

If you are completing this form for another person, what is your relationship?_____

Health Questionnaire: PLEASE CIRCLE YOUR ANSWER

1. Has there been any change in your general health within the past year---------- yes no
2. Last physical examination was on_____
3. Are you now under the care of a physician---------- yes no
   if yes, what for_____
4. The name and address of physician_____phone_____
5. Have you had any serious illness or operation---------- yes no
   if yes, what for_____
6. In the past five years have you been hospitalized or had a serious illness---------- yes no
   if yes, what for_____
7. Do you have or had any of the following diseases or problems.----------
   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 chest pain 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 a skin rash---------- yes no
   h. fainting spells or seizures---------- yes no
   i. diabetes---------- **yes no**
      1) do you have to urinate more than six 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
8. Abnormal bleeding associated with extractions, surgery, or trauma ---------- yes no
   a. do you bruise easily---------- yes no
   b. have you ever required a blood transfusion---------- yes no
      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. Are you taking any drug or medication---------- yes no
    if yes, 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. aspirin---------- yes no
    h. insulin, tolbutamide (orinase) or similar drug---------- yes no
    i. digitalis or drugs for heart trouble---------- yes no
    j. nitroglycerin---------- yes no
    k. other_____
13. Are you allergic 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 dental treatment---------- yes no
    if yes, explain_____
15. Do you have any disease, condition, or problem not listed above that you think I should know about---------- yes no
    if yes, 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 contact lenses---------- yes no

Women:

18. Are you pregnant---------- yes no
19. Do you have any problems associated with your menstrual period---------- yes no

Main Dental Problem:

How did you hear of our practice?

_____signature of patient or guardian.