# Health Questionnaire

*Mail this completed form to:*
Dr. Tom Kraus Dentistry
35 West Scott St.
Fond du Lac, WI 54935

Date __/__/____

Name ______________________________________________ Date of birth __/__/____ Age ___

When was your last dental visit?........................................................................................ Date __/__/____

Are you having a dental concern at this time?................................................ Yes No

If yes, please describe ______________________________________________________________________

Have you had any physician visit within the last 12 months?.......................... Yes No Date __/__/____

If yes, the reason for your visit was ____________________________________________________________

Have you been in the hospital within the past 5 years? ................................. Yes No Date __/__/____

If yes, the reason for your hospitalization was ___________________________________________________

Are you taking any medications or pills of any kind, prescription
or non-prescription (including birth control pills)? ........................................ Yes No

If yes, please list medications ________________________________________________________________

Are you allergic to or had any ill effects from any drug, medicine,
or other substance?........................................................................................ Yes No

If yes, what? _______________________________________________________________________________

Have you ever been diagnosed or treated for chemical dependency,
including alcohol?.......................................................................................... Yes No

If yes, what? _______________________________________________________________________________

Have you or any family members had diabetes? ............................................ Yes No

If yes, who? ________________________________________________________________________________

Is there a concern that you may have been exposed to the human
immunodeficiency virus (AIDS)?...................................................................... Yes No

## Have You Ever Had or Been Treated for…

Abnormal bleeding from cut/extraction ..... Yes No
Anemia...................................................... Yes No
Anorexia/Bulimia ....................................... Yes No
Arthritis..................................................... Yes No
Asthma...................................................... Yes No
Blood Transfusions .................................... Yes No
Bone Surgery ............................................. Yes No
Convulsions or Epilepsy .............................. Yes No
Enzyme Deficiency..................................... Yes No
Fainting Spells or Seizures .......................... Yes No
Hepatitis .................................................... Yes No
High or Low Blood Pressure ....................... Yes No
History of Heart Murmur............................ Yes No

Hives or skin rash .......................................Yes No
Inflammatory Rheumatism ..........................Yes No
Jaundice or liver disease .............................Yes No
Kidney or liver involvement ........................Yes No
Nervous Disorders.......................................Yes No
Rheumatic Fever .........................................Yes No
Sinus Trouble...............................................Yes No
Sore or bleeding gums ................................Yes No
Stomach Ulcers............................................Yes No
Tuberculosis ................................................Yes No
Tumor or malignant growth.........................Yes No
Venereal Disease.........................................Yes No
X-ray Therapy to head or neck.....................Yes No

## Do You…

Ever have swollen ankles............................ Yes No
Fatigue easily ............................................. Yes No
Get short of breath easily ........................... Yes No
Have chest pain upon exertion................... Yes No

Require extra pillows to sleep.....................Yes No
Wear contact lenses....................................Yes No
Have a pacemaker, prosthetic valves,
or joint replacement ..................................Yes No

Have you ever had heart trouble, heart disease, congenital heart lesions,
heart attack, coronary occlusion, arteriosclerosis, stroke, or heart surgery? .. Yes No

If yes, for what? ______________________________________________________________

Do you use any tobacco products? .................................................................Yes No

If yes, how much? ___________________________ For how long?___________________________________

Females: Are you pregnant?.............................................................................Yes No

If yes, when is your due date? __/__/____

Use this space for any explanation of information you think we should know regarding your medical condition that may not have been covered. ___________________________________________________________

______________________________________________________________________________________________

## Patient Information

Address:________________________________ City: ______________________State:________Zip: _________

Phone: (___) __________________Work phone: (___) ________________ Cell phone: (___) ________________

Employer: ______________________________________________________________

Address: _____________________________City:______________________State:______ Zip: ________

If student, name of school: ____________________City/State:______________________________ [] FT [] PT

Check appropriate box: [] Minor [] Single [] Married [] Widowed [] Separated [] Divorced

Spouse or Parent's name: ______________________________________________________________________

Spouse or Parent's Employer: ___________________________________ Work phone: (___)________________

Whom may we thank for referring you?_______________________________________________________________

Person to contact in case of emergency: ____________________________________________________________

Email address____________________________________________________________________________________

## Insurance Information

Name of Insured _____________________________ DOB __/__/____ Relationship to patient ______________

SSN: _______________ Employer: ______________________________ Work phone: (___)________________

Employer address:_______________________________ City ______________________ State: ____Zip: ______

Insurance Company: _____________________________ Group # __________________ ID# ________________

Insurance Co. address: _______________________________________________Phone: (___) ________________

**---- Do you have any additional insurance? [] Yes [] No If yes, complete the following ---**

Name of Insured _____________________________ DOB __/__/____ Relationship to patient ______________

SSN: _______________ Employer: ______________________________ Work phone: (___)________________

Employer address:_______________________________ City ______________________ State: ____Zip: ______

Insurance Company: _____________________________ Group # __________________ ID# ________________

Insurance Co. address: _______________________________________________Phone: (___) ________________

*My signature below confirms that this health questionnaire is accurate to the best of my knowledge.*

Signature _________________________________________________________________ Date __/__/____

Signature _________________________________________________________________ Updated __/__/____

Signature _________________________________________________________________ Updated __/__/____