DENTAL HEALTH QUESTIONNAIRE	Personal Data - Privacy Act of 1974	BUMEDINST 6600.12B

DO YOU HAVE OR HAVE YOU EVER HAD:

(Check each item)	YES	NO	DON'T KNOW	*(Check each item)*	YES	NO	DON'T KNOW	*(Check each item)*	YES	NO	DON'T KNOW
Epilepsy or Seizures	☐	☐	☐	Heart problems or Angina	☐	☐	☐	Ulcers (mouth or stomach)	☐	☐	☐
Depression, Anxiety, or Nervousness	☐	☐	☐	Hypertension (high blood pressure)	☐	☐	☐	Gastroesophageal reflux (GERD)	☐	☐	☐
Mental health conditions (including PTSD)	☐	☐	☐	Rheumatic fever	☐	☐	☐	Eating disorders	☐	☐	☐
Neurologic disorders (including TBI)	☐	☐	☐	Heart murmur or Heart defect	☐	☐	☐	Glaucoma (narrow or wide angle)	☐	☐	☐
Migraine or Chronic headaches	☐	☐	☐	Irregular heart beat	☐	☐	☐	Kidney problems	☐	☐	☐
Fainting or Dizziness	☐	☐	☐	Infective endocarditis	☐	☐	☐	Steroid medication(s)	☐	☐	☐
Stroke	☐	☐	☐	Prosthetic (artificial) heart valve(s)	☐	☐	☐	Hives	☐	☐	☐
Asthma	☐	☐	☐	Heart surgery	☐	☐	☐	Arthritis (rheumatoid or osteoarthritis)	☐	☐	☐
Emphysema, Bronchitis, or Lung disease	☐	☐	☐	Pacemaker	☐	☐	☐	Painful joints (including jaw)	☐	☐	☐
Sleep apnea	☐	☐	☐	Blood transfusion(s)	☐	☐	☐	Prosthetic (artificial) joint(s)	☐	☐	☐
Tuberculosis / PPD positive	☐	☐	☐	Liver disease	☐	☐	☐	Alcoholism or Alcohol abuse	☐	☐	☐
Chronic sinusitis/Recurring sinus infections	☐	☐	☐	Hepatitis - Type:	☐	☐	☐	Drug dependency or Drug abuse	☐	☐	☐
Cold sores (herpes)	☐	☐	☐	Diabetes	☐	☐	☐	Unexplained weight change	☐	☐	☐
Anemia	☐	☐	☐	Thyroid disease	☐	☐	☐	Cancer	☐	☐	☐
Sickle cell disease / trait	☐	☐	☐	Sexually transmitted disease(s)	☐	☐	☐	Chemotherapy or Radiation treatment	☐	☐	☐
G-6PD deficiency	☐	☐	☐	HIV+	☐	☐	☐	Osteoporosis	☐	☐	☐
Bleeding problems or Bruise easily	☐	☐	☐	Autoimmune disease	☐	☐	☐	History of bisphosphonate use	☐	☐	☐

Check each item below and describe any "Yes" answers to the right:	YES	NO	***Describe "Yes" answers below:***
1. Do you have any allergies (including medications, latex, or metals)?	☐	☐	
2. Are you currently taking any medications (over-the-counter, prescription, etc.)?	☐	☐	
3. Are you presently using any herbals, energy drinks, or supplements (such as ginseng, ginkgo biloba, willow bark, guarana extract, etc.)?	☐	☐	
4. Have you ever been hospitalized (including cancer treatment)?	☐	☐	
5. Are you currently under the care of a physician?	☐	☐	
6. Do you have any disease or condition not listed above?	☐	☐	
7. Are you currently experiencing abuse or neglect?	☐	☐	

8. HAVE YOU EVER:	YES	NO	***9. ARE YOU IN:***	YES	NO	***10. FEMALES, ARE YOU:***	YES	NO
8a. Been told not to donate blood?	☐	☐	*9a.* Flight status?	☐	☐	*10a.* On birth control?	☐	☐
8b. Used antibiotics before dental treatment?	☐	☐	*9b.* Personnel Reliability Program?	☐	☐	*10b.* Pregnant? (Est. delivery date?)	☐	☐
8c. Used antibiotics for a prolonged period?	☐	☐				*10c.* Breast feeding?	☐	☐

10. Any family history of:
☐ Cancer ☐ Heart disease
☐ Diabetes ☐ High blood pressure

11. Any social history of (if no, write "none"):
☐ Tobacco use (including E-cigarettes/vapor products) *Type and Frequency*: _____ *Years used*: _____
☐ Alcohol consumption *Type and Frequency*: _____

1.					☐	☐
Patient/Guardian Signature	Date	Dental Officer Name	Dental Officer Signature	Date	Medications Reconciled	Patient Identifiers Verified
2.					☐	☐
Patient/Guardian Signature	Date	Dental Officer Name	Dental Officer Signature	Date	Medications Reconciled	Patient Identifiers Verified
3.					☐	☐
Patient/Guardian Signature	Date	Dental Officer Name	Dental Officer Signature	Date	Medications Reconciled	Patient Identifiers Verified

SUMMARY OF PERTINENT FINDINGS/RECOMMENDED TREATMENT MODIFICATIONS (*Office use only*):

Patient Name (Last, First, Middle Initial)	Sex	Date of Birth (DD/MMM/YYYY)	Grade/Rate or Relationship to Sponsor
Sponsor's Name (if different from above)	Branch of Service	Active/Reserve	DOD Identification Number