Ian J. Langer, D.M.D. LLC

Practice Limited to Endodontics

N.J. Specialty Permit #3336

140 St. Paul Street Westfield, N.J. 07090 (908) 232-7668

HEALTH QUESTIONNAIRE

Circle One: Mr. Dr. Mrs. Miss Ms. Date_____

Name_____ Age_____

Street_____ Birth date_____

City, State_____ Zip_____ Phone ( )_____

Soc. Sec.No._____ Occupation_____ Business Ph._____

Cell Phone_____ Emergency Contact_____ Phone_____

Email Address_____ Whom may we thank for referring you?_____

Please answer all questions by circling yes or no and fill in blanks if needed.

1. Yes No… Has there been any change in your general health within the past year?
2. Yes No… Are you now under the care of a physician? Who?_____
   If yes, what is the condition being treated? _____
3. Yes No… Have you been hospitalized or had a serious illness during the past 5 years? If yes what was the problem? _____

Do you have, or have you had any of the following:

4. Yes No… Rheumatic Fever or Rheumatic Heart Disease?
5. Yes No… Heart murmur or congenital heart disease?
6. Yes No… Heart problems, Heart attack, pacemaker, artificial heart valve?
7. Yes No… High Blood pressure, Stroke, Aneurysm?
8. Yes No… Asthma, emphysema, or difficulty breathing?
9. Yes No… Angina or other chest pain?
10. Yes No… Seizures, convulsions or epilepsy?
11. Yes No… Diabetes?
12. Yes No… Hepatitis, jaundice or liver disease?
13. Yes No… AIDS, Venereal Disease, gonorrhea, syphilis?
14. Yes No… Have you ever tested positive for the HIV virus or ARC?
15. Yes No… Cancer/Chemotherapy?
16. Yes No… Stomach Ulcers?
17. Yes No… Kidney trouble or renal dialysis?
18. Yes No… Tuberculosis?
19. Yes No… Psychiatric therapy?
20. Yes No… Thyroid Disease? Hypothyroid, Hyperthyroid?
21. Yes No… Arthritis, artificial bones or joints (prosthesis) implanted?
22. Yes No… Hemophilia, anemia or other blood disorders?
23. Yes No… Have you had surgery or radiation therapy for a tumor, growth, cancer or other condition of the head, neck or mouth?
24. Yes No… Have you ever required a blood transfusion?
25. Yes No… Have you ever been denied permission to give blood?
26. Yes No… Have you any visual, hearing or other disabilities?
27. Yes No… Have you ever been in contact with an individual having AIDS or Hepatitis?
28. Yes No… Are you addicted to, use, or are recovering from drugs or alcohol?
29. Yes No… Do you have any other medical problems? What?_____