DEPARTMENT OF HOMELAND SECURITY
U.S. COAST GUARD

DENTAL HEALTH QUESTIONNAIRE

PRIVACY ACT STATEMENT

AUTHORITY: The authority for collection of information including social security number (SSN) is found in the Privacy Act of 1974, 5 U.S. .C. § 552a.

PURPOSE: The purpose of this form is to determine a member's fitness for dental care. This includes ascertaining if the member has been in the past, currently is, or needs to be treated for any and all medical conditions prior to the start of any dental procedure or visit.

ROUTINE USE: Information will be used by personnel within the Coast Guard to determine a member's health prior to dental care.

DISCLOSURE: In the case of military personnel, the requested information is mandatory. Failure to respond may preclude successful dental treatment for fitness of duty and may lead to administrative or disciplinary action against the member.

Are you in flight status? ☐ Yes ☐ No Occupation/Job: _____

Are you presently ill or under the care of a physician? ☐ Yes ☐ No

If yes, please describe: _____

Allergies (including medication, Latex, jewelry, metal, etc.): _____

Current medications (including aspirin, over-the-counter medications, etc.): _____

_____

History of hospitalizations: _____

Any family history of: ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Seizures

Have you ever had or do you now have:

	Yes	No	Don't Know		Yes	No	Don't Know		Yes	No	Don't Know
Epilepsy or Seizures	☐	☐	☐	Hemophilia	☐	☐	☐	Ulcers	☐	☐	☐
Fainting or dizziness	☐	☐	☐	Bruise or bleed easily	☐	☐	☐	Kidney problems	☐	☐	☐
Anxiety reaction	☐	☐	☐	Heart problems/Angina	☐	☐	☐	Venereal disease	☐	☐	☐
Stroke	☐	☐	☐	Hypertension	☐	☐	☐	Diabetes	☐	☐	☐
Glaucoma	☐	☐	☐	Rheumatic fever	☐	☐	☐	Thyroid disease	☐	☐	☐
Cold Sores (Herpes)	☐	☐	☐	Heart murmur	☐	☐	☐	HIV/AIDS	☐	☐	☐
Persistent cough	☐	☐	☐	Mitrol valve prolapse	☐	☐	☐	Arthritis	☐	☐	☐
Emphysema	☐	☐	☐	Congenital heart lesions	☐	☐	☐	Painful joints (incl. jaw)	☐	☐	☐
TB/PPD positive	☐	☐	☐	Heart surgery	☐	☐	☐	Prosthetic joint	☐	☐	☐
Asthma	☐	☐	☐	Prosthetic heart valve	☐	☐	☐	Hives	☐	☐	☐
Hay Fever	☐	☐	☐	Pacemaker	☐	☐	☐	Steroid medication	☐	☐	☐
Sinus problems	☐	☐	☐	Blood transfusions	☐	☐	☐	Drug addiction	☐	☐	☐
Anemia	☐	☐	☐	Liver disease	☐	☐	☐	Alcoholism	☐	☐	☐
Sickle cell disease	☐	☐	☐	Yellow jaundice	☐	☐	☐	Unexplained weight change	☐	☐	☐
G-6-PD deficiency	☐	☐	☐	Hepatitis-type:	☐	☐	☐	Cancer/radiation therapy	☐	☐	☐

Have you ever been told that you should not donate blood? ☐ ☐ ☐

Have you ever been told that you need antibiotics before dental treatment? ☐ ☐ ☐

Females: Are you taking birth control pills? ☐ ☐ ☐

Are you or might you be pregnant? Estimated delivery: _____ ☐ ☐ ☐

Do you have any disease, condition, or problem not listed above? ☐ ☐ ☐

Please describe: _____

_____ _____
Patient's Signature Date

Summary of pertinent findings/recommended treatment modifications (Dentist's use only): B/P: _____

Wellness Screen:

Tobacco use: _____ Exercise: _____ Diet/nutrition: _____

Alcohol use: _____ Stress: _____ Seat belt use: _____

_____ _____
Dental Officer's Signature Date

Patient's Identification:			
	Patient's Name (Last, First, MI):		Sex: ☐ Male ☐ Female
	Date of Birth:	Relationship to Sponsor:	Service:
	Sponsor's Name:		Rank/Grade:
	DoD Beneficiary Number:	Organization/Command:	
	Phone Number Day:	Evening:	