MEDICAL HISTORY QUESTIONNAIRE

MEDICAL ALERT:

NAME: MR./MISS/MRS./MS./DR.

____

DATE OF BIRTH (DAY/MONTH/YEAR):

_________ /_________ /_________

ADDRESS (HOME):

____

____

PHONE:________________________

ADDRESS (BUSINESS):_____________

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PHONE:_________________________

OCCUPATION:____________________

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME:_______________________________

RELATIONSHIP:_________________________

DAY-TIME PHONE:______________________

NAME OF FAMILY DOCTOR:______________

PHONE & ADDRESS:____________________

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(1) NAME OF MEDICAL SPECIALIST:

____

AREA OF SPECIALITY:___________________

PHONE & ADDRESS:____________________

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WHO REFERRED YOU TO OUR OFFICE?____

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

1. Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why?

YES ______NO ______NOT SURE/MAYBE____

2. When was your last medical checkup?____

3. Has there been any change in your general health in the past year? If yes, please explain.

YES_____NO_____NOT SURE/MAYBE____

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list. YES_____NO_____NOT SURE/MAYBE_____________________________

____

5. Do you have any allergies? If you answered yes, please list using the categories below:

YES_____NO_____NOT SURE/MAYBE____

a) medications:____

b) latex/rubber products:____

c) other (e.g. hay fever,
foods):____

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain. YES_____NO_____NOT SURE/MAYBE______________________________

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7. Do you have or have you ever had asthma? YES_____NO_____NOT SURE/MAYBE_______

8. Do you have or have you ever had any heart or blood pressure problems?
YES_____NO_____NOT SURE/MAYBE_____

9. Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant? YES_____NO_____NOT SURE/MAYBE_____

10. Do you have a prosthetic or artificial joint? YES_____NO_____NOT SURE/MAYBE_____

11. Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy?
YES_____NO_____NOT SURE/MAYBE_____

12. Have you ever had hepatitis, jaundice or liver disease?
YES_____NO_____NOT SURE/MAYBE_____

13. Do you have a bleeding problem or bleeding disorder?
YES_____NO_____NOTSURE/MAYBE_____

14. Have you ever been hospitalized for any illnesses or operations? If yes, please explain.
YES_____NO_____NOT SURE/MAYBE_____

15. Do you have or have you ever had any of the following? Please check.

____ chest pain, angina	____ seizures (epilepsy)	____ stomach ulcers
____ heart attack	____ steroid therapy	____ arthritis
____ stroke	____ rheumatic fever	____ kidney disease
____ shortness of breath	____ lung disease	____ thyroid disease
____ heart murmur	____tuberculosis	____ drug/alcohol dependency
____ mitral valve prolapse		____ osteoporosis medications
(e.g. o pacemaker	____ cancer	ie: Fosamax, Actonel)

16. Are there any conditions or diseases not listed above that you have or have had? If so, what? YES_____NO_____NOT SURE/MAYBE_____________________________________

17. Are there any diseases or medical problems that run in your family?(e.g. diabetes, cancer or heart disease) YES_____NO_____NOT SURE/MAYBE_______________________________

18. Do you smoke or chew tobacco products? YES_____NO_____NOT SURE/MAYBE_____

19. Are you nervous during dental treatment? YES_____NO_____NOT SURE/MAYBE_____

20. For women only: Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date? YES_____NO_____NOT SURE/MAYBE________________________________

To the best of my knowledge, the above information is correct:

PATIENT/PARENT/GUARDIAN SIGNATURE:________________________ DATE:_____________

DENTIST SIGNATURE:________________________________ DATE:_______________________

DENTIST'S NOTES____

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