

# MEDICAL HISTORY QUESTIONNAIRE

## MEDICAL ALERT:

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

\_\_\_\_\_

DATE OF BIRTH: (DAY/MONTH/YEAR) / /

\_\_\_\_\_

ADDRESS (HOME):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

HOME PHONE: \_\_\_\_\_

DAYTIME PHONE NUMBER: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

WHO REFERRED YOU TO OUR OFFICE?

\_\_\_\_\_

\_\_\_\_\_

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

DAYTIME PHONE NUMBER: \_\_\_\_\_

NAME OF FAMILY DOCTOR: \_\_\_\_\_

PHONE OR ADDRESS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(1) NAME OF MEDICAL SPECIALIST: \_\_\_\_\_

Area of Specialty: \_\_\_\_\_

Phone or Address: \_\_\_\_\_

(2) NAME OF MEDICAL SPECIALIST: \_\_\_\_\_

Area of Specialty: \_\_\_\_\_

Phone or Address: \_\_\_\_\_

**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 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

\_\_\_\_\_

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 heart murmur, mitral valve prolapse or rheumatic fever?  
 YES  NO  NOT SURE/MAYBE
10. Do you have a prosthetic or artificial joint?  YES  NO  NOT SURE/MAYBE
11. Have you ever been advised by you doctor to take antibiotics before dental treatment?  
 YES  NO  NOT SURE/MAYBE
12. Do you have any conditions or therapies that could affect your immune system e.g. leukemia, ADIS, HIV infection, radiotherapy, chemotherapy?  YES  NO  NOT SURE/MAYBE
13. Have you ever had hepatitis, jaundice or liver disease?  YES  NO  NOT SURE/MAYBE
14. Do you have a bleeding problem or bleeding disorder?  YES  NO  NOT SURE/MAYBE
15. Have you ever been hospitalized for any illness or operations? If yes, please explain  
 YES  NO  NOT SURE/MAYBE

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

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> chest pain, angina      | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> pacemaker      | <input type="checkbox"/> steroid therapy        |
| <input type="checkbox"/> heart-attack            | <input type="checkbox"/> stroke              | <input type="checkbox"/> lung disease   | <input type="checkbox"/> prosthetic heart valve |
| <input type="checkbox"/> tuberculosis            | <input type="checkbox"/> diabetic            | <input type="checkbox"/> stomach ulcers | <input type="checkbox"/> kidney disease         |
| <input type="checkbox"/> thyroid disease         | <input type="checkbox"/> diet pill therapy   | <input type="checkbox"/> arthritis      | <input type="checkbox"/> seizures               |
| <input type="checkbox"/> drug/alcohol dependency | <input type="checkbox"/> cancer              |   |   |

17. Are there any conditions or diseases not listed above that you have or have had? If so, what?  
 YES  NO  NOT SURE/MAYBE
18. Are there any diseases or medical problems that run in you family? (e.g. diabetes, cancer or heart disease)  
 YES  NO  NOT SURE/MAYBE
19. Do you smoke or chew tobacco products?  YES  NO  NOT SURE/MAYBE
20. Are you nervous during dental treatment?  YES  NO  NOT SURE/MAYBE
- 21 For women only: Are you breast feeding or pregnant? If pregnant, what is the expected delivery date?  
 YES  NO  NOT SURE/MAYBE

22. When was your last dental appointment? For what?

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

PATIENT/PARENT/GUARDIAN SIGNATURE:

DATE:

DENTIST SIGNATURE:

DATE: