MEDICAL HISTORY QUESTIONNAIRE

MEDICAL ALERT:

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

_____

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

_____

ADRESS (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.

❒chest pain, angina	❒shortness of breath	❒pacemaker	❒steroid therapy
❒heart-attack	❒stroke	❒lung disease	❒prosthetic heart valve
❒tuberculosis	❒diabetic	❒stomach ulcers	❒kidney disease
❒thyroid disease	❒diet pill therapy	❒arthritis	❒seizures
❒drug/alcohol dependency	❒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:**

_____