Medical History Questionnaire

MEDICAL ALERT:

Name: Mr./Miss/Mrs./Ms./Dr.
Last:
First:
Date Of Birth (Day/Month/Year):

Address (Home):

Home Phone:
Mobile Phone:
Work Phone: Ext:
Email:
Employer:
Who Referred You To Our Office?

Do You Have Any Family/Friends Who Are Already Patients?

Name Of Family Doctor:

Phone Or Address:

In Case Of Emergency, We Should Notify:
Name:

Relationship:

Daytime Phone:

Dental Insurance Provider:

Policy Holder Name /D.O.B

Group #
Certificate #

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

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

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

☐Yes ☐ No ☐ Not Sure

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

a) medications	☐ Yes ☐ No ☐Not Sure
b) latex/rubber products	☐ Yes ☐No ☐ Not Sure
c) other (e.g. hayfever, foods)	☐ Yes ☐ No ☐ Not Sure
Please list	

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

☐ Yes ☐ No ☐ Not Sure

7. Do you have or have you ever had asthma?

☐ Yes ☐ No ☐ Not Sure

8. Do you have or have you ever had any heart or blood pressure problems?

☐ Yes ☐ No ☐ Not Sure

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

10. Do you have a prosthetic or artificial joint?

☐ Yes ☐ No ☐ Not Sure

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

12. Have you ever had hepatitis, jaundice or liver disease?

☐ Yes ☐ No ☐ Not Sure

13. Do you have a bleeding problem or bleeding disorder?

☐ Yes ☐ No ☐ Not Sure

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

☐ Yes ☐ No ☐ Not Sure

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

☐chest pain, angina
☐heart attack
☐stroke
☐shortness of breath
☐rheumatic fever
☐mitral valve
☐prolapse
☐heart murmur
☐pacemaker

☐lung disease
☐tuberculosis
☐cancer
☐steroid therapy
☐diabetes
☐stomach ulcers
☐arthritis
☐seizures (epilepsy)
☐kidney disease

☐thyroid disease
☐drug/alcohol dependency
☐osteoporosis
☐medications (e.g. 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

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

☐ Yes ☐ No ☐ Not Sure

18. Do you smoke or chew tobacco products?

☐ Yes ☐ No ☐ Not Sure

19. Are you nervous during dental treatment?

☐ Yes ☐ No ☐ Not Sure

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

☐ Yes ☐ No ☐ Not Sure

Medical History Questionnaire

DENTAL HISTORY QUESTIONNAIRE

1.	When was your last dental visit?
2.	When did you last have dental x-rays?
3.	How often do you brush your teeth?
4.	How often do you floss your teeth?

5. Have you been seeing a dentist regularly?
☐YES ☐ NO ☐ NOT SURE

6. Do any of your teeth ache?
☐ YES ☐ NO ☐ NOT SURE

7. Have you ever been advised to take antibiotics before dental appointments?
☐ YES ☐ NO ☐ NOT SURE

8. Do your gums bleed when you brush?
☐ YES ☐ NO ☐ NOT SURE

9. Do you have any pain when you chew?
☐YES ☐ NO ☐ NOT SURE

10. Do you feel that you have bad breath?
☐ YES ☐ NO ☐ NOT SURE

11. Have you ever been in a vehicle accident or experienced any blows to your jaw?
☐ YES ☐ NO ☐ NOT SURE

Please list anything else not mentioned above regarding your past dental history

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

____ ________________________

PATIENT/PARENT/GUARDIAN SIGNATURE **DENTIST SIGNATURE**

DATE DATE

Date	Medical Updates/Notes