

MEDICAL HISTORY QUESTIONNAIRE

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

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

ADDRESS (HOME):

PHONE:

ADDRESS (BUSINESS):

PHONE:

OCCUPATION:

WHO REFERRED YOU TO OUR OFFICE?

IN CASE OF EMERGENCY WE SHOULD NOTIFY:

NAME

RELATIONSHIP:

DAYTIME PHONE:

NAME OF FAMILY DOCTOR

PHONE OR ADDRESS:

(1) NAME OF MEDICAL SPECIALIST

AREA OF SPECIALITY:

PHONE OR ADDRESS:

(2) NAME OF MEDICAL SPECIALIST

AREA OF SPECIALITY:

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. hayfever, 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 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 your 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, AIDS, 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 your 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"/> Steriod therapy | <input type="checkbox"/> Seizures (epilepsy) |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Prosthetic heart valve | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Cancer | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Stomach ulcers | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diet pill therapy | <input type="checkbox"/> Drug/alcohol dependancy | | |
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17. Are there any conditions or diseases not listed above that you have or have had? If so, what?

18. Are there any diseases or medical problems that run in your 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

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

PATIENT/PARENT/GUARDIAN SIGNATURE:

DATE:

DENTIST SIGNATURE:

DATE:

DENTIST NOTES: