MEDICAL HISTORY QUESTIONNAIRE

MEDICAL ALERT:

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

____

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

ADDRESS:

____

____

EMPLOYER:

WORK PHONE #:

EMAIL:

____

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 NEDICAL SPECIALIST:

AREA OF SPECALITY: _

PHONE OR ADRESS:

(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 question 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 CHECHKUP?

____

3. HAS 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 MEDICATION, 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) MEDICATION
B) LATEX/RUBBER PRODUCT
C) OTHER (E.G. HAYFEVER, FOODS)

____

6. HAVE YOU HAD A PECILIAR OR ADVERSE REACTION TO ANY MEDICINES OR INJECTION? IF YES PLEASE EXPLAIN.

YES NO NOT SURE /MAYBE

____

7. DO YOU HAVE OR HAVE 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 CONDITION 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 HEPATITS, JAUNDICE OR LIVER DISEASE? YES NO NOT SURE / MAYBE

13. DO YOU HAVE BLEEDING PROBLEM OR BLEEDING DISORDER?
YES NO NOT SURE / 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	RHEUMATIC, FEVER	PACEMAKER	STEROID THERAPY	SEIZURES(EPILEPSY)	OSTEOPOROSIS
HEART ATTACK	MITRAL VALVE	LUNG DISEASE	DIABETES	KIDNEY DISEASE	MEDICATIONS
STROKE	PROLAPSE	TUBERCULOSIS	STOMACH ULCERS	THYROID DISEASE	(e.g. FOSMAX
SHORTNESS OF BREATH	HEART MURMUR	CANCER	ARTHRITIS	DRUG/ALCOHOL	ACTONEL)
				DEPENDENCY	

16. ARE THERE ANY CONDITION OR DISEASES NOT LISTID ABOVE THAT YOU HAVE OR HAVE HAD? IF SO WHAT?
YES NO NOT SURE / MAYBE

17. ARE THERE ANY DISEASES OR MIDICAL PRPBLEMS 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 EXPEC TED DELIVE RY 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: