MEDICAL HISTORY QUESTIONNAIRE

MEDICAL ALERT:

NAME:

DATE OF BIRTH (Day/Month/Year)

ADDRESS, CITY & POSTAL CODE:

PHONE:

OCCUPATION:

Email address:

EMERGENCY CONTACT

NAME:

RELATIONSHIP:

DAY TIME PHONE:

NAME OF FAMILY DOCTOR:

PHONE OR ADDRESS:

NAME OF MEDICAL SPECIALIST:

PHONE OR ADDRESS:

Do you Have Dental insurance ?

How did you hear about our office?

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?

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.

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? Please list:

5. Do you have any allergies? If you answered yes, please list. (eg. Medication, latex, seasonal.)

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? Please explain.

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

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

Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever?

10. Do you have a prosthetic or artificial joint?

Have you ever been advised by your doctor to take antibiotics before dental treatment?

Do you have any conditions or therapies that could affect your immune system? E.g. Leukemia, AIDS, HIV infection, radiotherapy, chemotherapy?

Have you ever had hepatitis, jaundice or liver disease?

Do you have a bleeding problem or bleeding disorder?

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

Do you have or have you ever had any of the following? Please circle:

Chest pain, angina shortness of breath pacemaker steroid seizures (epilepsy)
drug/alcohol dependency heart attack lung disease Diabetes kidney disease
stroke prosthetic heart valve Tuberculosis stomach ulcers thyroid disease
Cancer arthritis diet pill therapy

Are there any conditions not listed above that you have or have had? If so, what?

Are there any diseases or medical problems that run in your family? (e.g. Diabetes, Heart disease)

19. Do you smoke or chew tobacco products?
20. Are you nervous during dental treatment?
21. When was your last dental visit?
22. When did you last have dental x-rays?
23. How often do you brush/floss your teeth?
24. Have you been seeing a dentist regularly? If so how often?
25. Do any of your teeth ache?
26. Do your gums bleed when you brush?
27. Do you feel that you have bad breath?
28. Are you being followed up by a dental specialist?
29. **FOR WOMEN ONLY:** Are you breast feeding or pregnant? If pregnant, what is the expected delivery date?

Please list anything else regarding your past dental history:

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS CORRECT: I consent to whatever procedures, anesthetics and/or x-rays that are necessary for the treatment of my case and fees associated with these services.

PATIENT/PARENT/GUARDIAN SIGNATURE:__________________________ DATE:

DENTIST SIGNATURE:____ DATE: