MEDICAL HISTORY QUESTIONNARE

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

DATE OF BIRTH (MO/DAY/YR): / /

ADDRESS (HOME):

PHONE:

OCCUPATION:

WHO REFERRED YOU TO OUR OFFICE?

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME:

RELATIONSHIP:

DAY-TIME PHONE:

NAME OF FAMILY DOCTOR:

PHONE OR ADDRESS:

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 conditions at the present or have you been treated within the past year? If so, why?
❒ YES ❒ NO ❒ NOT SURE/MAYBE

2. Has there been any change in your general health in the past year? If yes, please explain.
❒ YES ❒ NO ❒ NOT SURE/MAYBE

3. Are you taking any medications, non-prescription drugs, or herbal supplements of any kind? If yes, please list.
❒ YES ❒ NO ❒ NOT SURE/MAYBE

Name of Drug	Amount	What are you taking it for?	How long have you been taking it?

4. Do you have any 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)

5. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.
❒ YES ❒ NO ❒ NOT SURE/MAYBE

6. Have you ever been hospitalized for an illness or operation? If yes, explain: ❒ YES ❒ NO ❒ NOT SURE/MAYBE

7. Do you have or have you ever had any heart or blood pressure problems? ❒ YES ❒ NO ❒ NOT SURE/MAYBE

8. 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

9. Do you have a prosthetic or artificial joint? ❒ YES ❒ NO ❒ NOT SURE/MAYBE

10. Have you ever taken an antibiotic (premedicated) before seeing your dentist? ❒ YES ❒ NO ❒ NOT SURE/MAYBE

11. Do you have any conditions or therapies that could affect your immune system, such as leukemia, radiotherapy, chemotherapy, AIDS, HIV infection? ❒ YES ❒ NO ❒ NOT SURE/MAYBE

12. Have you ever had hepatitis, jaundice, or liver disease? ❒ YES ❒ NO ❒ NOT SURE/MAYBE

13. Do you have a bleeding problem or bleeding disorder? ❒ YES ❒ NO ❒ NOT SURE/MAYBE

14. Have you been diagnosed or treated for Sleep Apnea, excessive snoring, or used a CPAP machine?
❒ YES ❒ NO ❒ NOT SURE/MAYBE

15. Do you have or have you ever had any of the following? Please check <u>all</u> that apply:

❒ chest pain, angina	❒ rheumatic fever	❒ pacemaker	❒ steroid therapy	❒ seizures (epilepsy)	❒ osteoporosis
❒ heart attack	❒ mitral valve prolapse	❒ lung disease	❒ kidney disease	❒ diabetes	medications (e.g. Fosamax, Actonel)
❒ stroke		❒ tuberculosis	❒ stomach ulcers	❒ thyroid disease	
❒ shortness of breath	❒ heart murmur	❒ cancer	❒ acid reflux/GERD	❒ drug/alcohol dependency	❒ asthma

16. Are there any conditions or diseases not listed above that you have or have had? If so, what?
❒ YES ❒ NO ❒ NOT SURE/MAYBE

17. Do you smoke or chew tobacco products? If so, how much per day? ❒ YES ❒ NO ❒ NOT SURE/MAYBE

18. **For women only:** Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date?
❒ YES ❒ NO ❒ NOT SURE/MAYBE

DENTAL INFORMATION

When was your last dental check up and cleaning? _____

I previously saw my dentist for: ❒ regular check ups ❒ emergency care

What is your daily oral hygiene routine? What type of toothpaste and/or mouth rinse do you use?

Are your teeth sensitive to hot/cold, sweets or pressure?	❒ YES ❒ NO	Are you nervous during dental treatment?	❒ YES ❒ NO
Do your gums bleed when you brush or floss?	❒ YES ❒ NO	Do you clench or grind your teeth?	❒ YES ❒ NO
Does your bite feel normal and comfortable?	❒ YES ❒ NO	Do you participate in any active sports?	❒ YES ❒ NO
Do you have any esthetic concerns?	❒ YES ❒ NO	Does your mouth feel dry?	❒ YES ❒ NO
Have you ever had orthodontic (braces) treatment?	❒ YES ❒ NO	Have you ever had jaw or TMJ problems?	❒ YES ❒ NO
Do you snack frequently or eat a lot of sugar?	❒ YES ❒ NO	Have you had trauma to your head or neck?	❒ YES ❒ NO

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

<u>Patient/Parent/Guardian Signature:</u> _____ <u>Date</u> _____

<u>Dentist Signature</u> _____ <u>Date</u> _____