MEDICAL HISTORY QUESTIONNAIRE

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

_____

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

_____

ADDRESS (HOME):

_____

_____

PHONE:

_____

OCCUPATION:

_____

HEIGHT:_____ WEIGHT:_____ (for BMI calculation)

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. hay fever, 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/disorder or take anticoagulation drugs? ❒ YES ❒ NO ❒ NOT SURE/MAYBE

14. 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 medications (e.g. Fosamax, Actonel)
❒ heart attack	❒ mitral valve prolapse	❒ lung disease	❒ kidney disease	❒ diabetes	
❒ stroke		❒ tuberculosis	❒ stomach ulcers	❒ thyroid disease	
❒ shortness of breath	❒ heart murmur	❒ cancer	❒ acid reflux/GERD	❒ drug/alcohol dependency	❒ asthma

_____

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

_____

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

_____

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

_____

18. Sleep Disorder & Airway Assessment Questions:

Has anyone ever told you that you stop breathing while asleep?	Y	N
Have you ever been involved in any type of accident because you nodded off or fell asleep?	Y	N
Have you ever fallen asleep while driving?	Y	N
Have you ever woken up suddenly gasping for air, heart racing, or shortness of breath?	Y	N
Do you grind your teeth?	Y	N
Do you snore or has someone ever told you that you snore?	Y	N
Does anyone in your family have a history or snoring or a diagnosed sleep apnea?	Y	N
Do you feel tired or sleepy throughout the day?	Y	N
Do you rapidly fall asleep at night (under ten (10) minutes)?	Y	N
Once you fall asleep, do you have trouble staying asleep?	Y	N
Do you find it difficult to manage your weight?	Y	N
Do you suffer from headaches during the morning or during the night?	Y	N
Have you ever been diagnosed with high blood pressure or taken medication for it?	Y	N
Do you suffer from acid reflux (GERD or LPRD)?	Y	N
Do you suffer from heart disease or have you had a stroke?	Y	N
Have you ever been diagnosed with any type of sleep disorder?	Y	N
Has it ever been recommended that you use a CPAP device?	Y	N
Do you frequently remember your dreams?	Y	N

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> _____