Medical History Questionnaire

Name _____

Please answer all questions **by checking a box under YES or NO.** (Please do not draw a line.)
Your responses will be held strictly confidential and will only be used to help assess your medical condition.
If you have any hesitations, please express your concern to a member of our team.

DO YOU HAVE, OR DID YOU EVER HAVE, ANY OF THE FOLLOWING?

Cardiovascular:

YES	NO	
❑	❑	High blood pressure
❑	❑	Heart disease from childhood
❑	❑	Heart murmur
❑	❑	Rheumatic fever
❑	❑	Use of Phen-Fen
❑	❑	Pacemaker
❑	❑	Vascular graft
❑	❑	Heart valve replacement
❑	❑	Heart attack
❑	❑	Heart surgery
❑	❑	Congestive heart failure
❑	❑	Angina (chest pain)
❑	❑	Irregular heart beat
❑	❑	**Stroke**

Respiratory:

YES	NO	
❑	❑	Asthma
❑	❑	Emphysema
❑	❑	Tuberculosis

Other _____

Musculo-Skeletal/CNS/ Developmental:

YES	NO	
❑	❑	Joint replacement (Date of Surgery_____)
❑	❑	Osteoarthritis
❑	❑	Rheumatoid arthritis
❑	❑	Spinal cord injury
❑	❑	Seizures
❑	❑	Cerebral palsy
❑	❑	Mental retardation
❑	❑	Dementia
❑	❑	Osteoporosis
❑	❑	Hormone Replacement: IV or Oral

Endocrine/Hematologic/Oncologic/Immune:

YES	NO	
❑	❑	Diabetes
❑	❑	Thyroid disease
❑	❑	Hemophilia
❑	❑	Sickle cell disease
❑	❑	Bleeding tendency
❑	❑	Anemia
❑	❑	Cancer
❑	❑	Radiation therapy
❑	❑	Chemotherapy
❑	❑	HIV infection/AIDS
❑	❑	Organ transplant
❑	❑	Blood transfusion, what year _____

Psychological:

YES	NO	
❑	❑	Anxiety/Nervousness
❑	❑	Depression
❑	❑	Mental health treatment
❑	❑	Eating disorder

GI/GU:

YES	NO	
❑	❑	Hepatitis (A, B, C, or other?)
❑	❑	Kidney dialysis
❑	❑	Ulcers
❑	❑	Sexually transmitted disease
❑	❑	Denied permission to give blood

Social:

YES	NO	
❑	❑	Do you use tobacco products?

If so, what kind? _____
How much? _____

❑	❑	Do you drink alcohol?

If so, how frequently?_____

❑	❑	Do you use recreational drugs?

OVER PLEASE ↳

Medication Allergy or Intolerance:

YES	NO	
❑	❑	Penicillin
❑	❑	Dental anesthetic ("Novocain")
❑	❑	Aspirin
❑	❑	Codeine
❑	❑	Latex products
❑	❑	Epinephrine
❑	❑	Food Allergies
❑	❑	Other _____

Medications:

YES	NO	
❑	❑	Are you taking any prescription medicine now?
❑	❑	Are you taking any over-the-counter items now?
❑	❑	Are you taking any herbal medications now?

For any YES answer above, please list name, dose, and regimen below:

Medications: • **Prescribed,** • **Over-the-counter** • **Herbal**	**Condition for which it is used**	**Dose**	**Regimen**	**Other**

What was the date of your last medical check-up? _____

Family: (Did a parent, sibling or child of yours have any of the following?)

YES	NO	
❑	❑	Diabetes
❑	❑	High blood pressure
❑	❑	Heart disease
❑	❑	Bleeding tendency

FEMALES:

YES	NO	
❑	❑	Are you pregnant now? If so, #____months
❑	❑	Do you take birth control pills?
❑	❑	Are you breast feeding now?

Do you have:

YES	NO	
❑	❑	Frequent hunger
❑	❑	Frequent thirst
❑	❑	Night sweats
❑	❑	Fainting spells
❑	❑	Visual impairment
❑	❑	Glaucoma
❑	❑	Hearing impairment

Do you have any medical conditions not already mentioned?

_____

_____

_____

To the best of my knowledge, all of the preceding answers are true. If I have any change in my health status, or any change in my medicines, I will inform my dental health care provider at my next appointment.

_____ _____

Signature of patient (or Parent or Guardian if patient is under 18) Date