Camino Dental Group

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MEDICAL HEALTH QUESTIONNAIRE

1. When was your last physical check-up? _____ Physician's Name _____ Phone _____
2. Have you been hospitalized or had a serious illness in the last five years? ---------- YES NO
3. Are you currently being treated by a specialist for an illness or medical condition? ---------- YES NO
4. Do you need to take antibiotics before dental visits? ---------- YES NO
5. Are you allergic or sensitive to drugs or local anesthetics? ---------- YES NO
6. Indicate which of the following you have had or currently have. Please circle **YES** or **NO**.

Diabetes ----------	YES	NO	Smoking ----------	YES	NO	Seizure, epilepsy----------	YES	NO
Heart Attack ----------	YES	NO	Alcohol use ----------	YES	NO	Shortness of breath ----------	YES	NO
Heart Failure ----------	YES	NO	Tobacco use ----------	YES	NO	Dizziness, nausea----------	YES	NO
Heart Surgery ----------	YES	NO	Drug Addiction ----------	YES	NO	Fainting ----------	YES	NO
High Blood Pressure -------	YES	NO	Bleeding problems ----------	YES	NO	Headaches, migraines --------	YES	NO
Stroke ----------	YES	NO	Sinus problems ----------	YES	NO	Anemia, blood disease -------	YES	NO
Heart Murmur ----------	YES	NO	Vomiting ----------	YES	NO	Glaucoma, cataract ----------	YES	NO
Hepatitis ----------	YES	NO	Stomach problems, ulcers ---	YES	NO	Eye Disease ----------	YES	NO
Mitral Valve Prolapse ------	YES	NO	Diarrhea ----------	YES	NO	Head Injuries ----------	YES	NO
Prosthetic Valve ----------	YES	NO	Constipation ----------	YES	NO	Body Injuries ----------	YES	NO
Joint Replacement ----------	YES	NO	Rheumatic fever ----------	YES	NO	Jaundice----------	YES	NO
Hip Replacement ----------	YES	NO	Rheumatism ----------	YES	NO	Liver Disease ----------	YES	NO
Pacemaker ----------	YES	NO	Arthritis ----------	YES	NO	Bladder Disease ----------	YES	NO
Osteoporosis ----------	YES	NO	Asthma ----------	YES	NO	Kidney Disease ----------	YES	NO
Cancer, tumor ----------	YES	NO	Tuberculosis ----------	YES	NO	Thyroid Disease ----------	YES	NO
Radiation therapy ----------	YES	NO	Emphysema ----------	YES	NO	Venereal Disease ----------	YES	NO
Chemotherapy ----------	YES	NO	Lung disease ----------	YES	NO	Mental Illness ----------	YES	NO
Immune Disease ----------	YES	NO	Allergies to food ----------	YES	NO	Nervousness ----------	YES	NO

7. Are you currently taking or have taken:
   - Recreational drugs? ---------- YES NO
   - Weight loss medication, herbal supplements? ---------- YES NO
   - Fen-phen, Redux, Pondimin, or other fenfluramine or dexfenfluramine related drugs? ---------- YES NO
   - Fosamax, Zometa, Aredia, Actonel, Didronel, Skelid, Boniva, Bonefos, or Ostec related drugs? ---------- YES NO
   - Do you take aspirin daily? ---------- YES NO
8. Women only.
   - Are you pregnant? ---------- YES NO
   - Are you nursing? ---------- YES NO
9. Do you have or have you had any diseases or medical problems NOT listed on this form? ---------- YES NO
10. Are you currently taking prescribed medications, or over-the-counter medicines? ---------- YES NO

PLEASE LIST ANY MEDICATIONS, AND EXPLAIN "YES" ANSWERS IF NEEDED

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To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes in my health.

Patient Name: _____ Patient Signature / Parent if minor: _____ Date: _____

DOCTOR'S NOTES **BP _____ pulse _____**

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Reviewed by Dr. _____ Date: _____