



NAME:

DOB:

Medical and Dental Information Questionnaire

Reason for your visit today:

Date of last dental visit: _____

Date of last dental cleaning: _____

Date of last full mouth x-rays: _____

MEDICAL INFORMATION

Yes No

Has there been any change in your general health within the past year? If so, please describe:

Are you now under the care of a physician? Please include the name and phone number for your physician.

Have you been hospitalized for any surgical operation or serious illness? If so, please describe:

Do you **have** or have you **had** any of the following conditions?

Yes No

- Rheumatic fever/ rheumatic heart disease
- Heart murmur
- Infective endocarditis
- Congenital heart defect
- Mitral valve prolapse
- Heart Disease
- Heart Attack
- Chest pain
- Heart Surgery
- Artificial heart valve or Pacemaker
- High blood pressure

Yes No

- Congestive heart failure
- Stroke
- Vascular disease
- Arthritis, Rheumatism
- Artificial Joints
- Prosthetic devices or implants
- Liver disease
- Hepatitis A B C (circle)
- Kidney trouble
- Diabetes, type I or II (circle)
- Thyroid problems
- Allergies, hay fever, hives
- Sinus trouble
- Asthma
- COPD
- Emphysema
- Tuberculosis
- Anemia
- Leukemia
- Tumors
- Chemotherapy
- Radiation therapy
- Ulcers
- Acid reflux
- Eating Disorder
- Bleeding disorder
- HIV or AIDS
- Venereal disease
- Glaucoma
- Alcohol/chemical dependency
- Psychiatric/Psychological care
- Anxiety and/or Depression

Yes No

- Latex sensitivity
- Epilepsy or Seizures
- Cold sores/fever blisters
- Do you use **tobacco**?
What kind? _____
How much? _____
How Long? _____

Do you have or have you had:

- Dry mouth much of the time?
- Sores in the mouth?
- White lesions in the mouth?
- Lumps or tumors in the mouth or neck?
- Blood transfusion?
- Unusual weight loss?
- Have you ever taken bone loss prevention drugs such as Fosamax, Actonel or Boniva?
- Do you have any **disease, condition or problem** not listed we should know about? Please describe:

Are you aware of having an **allergic** (or **adverse**) reaction to any substance or medication? Please list:

Medications being taken now—Please list all drugs, vitamins, pills and/or herbal remedies, including regular dosages of aspirin:

DENTAL INFORMATION

Yes No

- Have you ever been told to take a pre-medication (antibiotics) prior to dental treatment? If so, what do you take?

- Have you ever had an upsetting dental experience? If yes, please describe:

- Is it important for you to keep your teeth?
- Are you dissatisfied with the appearance of your teeth?
- Are you dissatisfied with the function of your teeth?
- Does food tend to become caught between your teeth?
- Do your gums often bleed while brushing?

Women:

Yes No

- Are you taking contraceptives (birth control prescriptions)?
- Are you pregnant or is it possible that you are pregnant?
If yes, how many months pregnant? _____
- Have you had a low birth weight baby?
- Are you presently nursing?

Yes No

- Have you noticed any loosening of teeth?
- Have you had an injury to your head, neck or jaw?

Habits – Do you:

- Clench your teeth while awake or asleep?
- Bite your lips, cheek or tongue?

Jaw Problems - have you noticed:

- Jaw noises (clicking or popping)?
- Jaw pain (joint, ear, side of face)?
- Difficulty opening or closing?
- Difficulty chewing?

Have you had/ever:

- Orthodontic treatment (braces)?
- Gum treatment?
- Your bite adjusted?
- Worn a guard or other appliance?

This space is to be used for further explanation of conditions or for questions you may have:

To the best of my knowledge, the above information is complete and correct.

Signature – Patient (or parent/guardian if patient is under age 18)

Date

History Review:

Dentist Signature: _____

Date: _____