



MEDICAL HISTORY QUESTIONNAIRE

First Name: _____ Last Name _____ Date _____

Date of Birth: _____ Age: _____ Sex: _____ Height _____ Weight _____

For the following questions, circle or select YES or NO, whichever applies.

Your answers are for our records only and will be kept confidential.

- | | | |
|---|-----|----|
| 1. Are you in good health? | Yes | No |
| 2. Has there been any change in your health in the past year? | Yes | No |
| 3. My last physical exam was on _____ | | |
| 4. Are you now under the care of a physician? | Yes | No |
| If so, for what condition? _____ | | |
| 5. Physician Name _____ Phone _____ | | |
| 6. Have you had any serious illness, operation or hospitalization within the past 5 years? | Yes | No |
| Please explain _____ | | |
| _____ | | |
| 7. Have you had an artificial joint replacement (knee, hip, etc.)? What year? | Yes | No |
| 8. Are you taking or have you ever taken Bisphosphonates for osteoporosis or chemotherapy for multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa or Prolia)? Please circle one if yes | Yes | No |
| 9a. Are you taking any blood thinners? (Xarelto, Coumadin, Plavix, Pradaxa, Aggrenox, Aspirin) Please circle one if yes | Yes | No |
| 9b. Are you taking any medicine(s) including diet pills, non-prescription, vitamins, homeopathic or natural remedies? | Yes | No |
| If so, please list _____ | | |
| _____ | | |
| _____ | | |
| 10. Do you have or have you had any of the following diseases or problems? If yes, please explain | | |
| a. Artificial valves, heart murmur, or mitral valve prolapse | Yes | No |
| b. Rheumatic Heart Disease, damaged heart valves | Yes | No |
| c. Heart trouble, heart attack, angina, stroke, arteriosclerosis or any other heart condition | Yes | No |
| 1. Chest pain upon exertion? | Yes | No |
| 2. Shortness of breath after mild exercise? | Yes | No |
| 3. Do your ankles swell? | Yes | No |
| d. High Blood Pressure | Yes | No |
| e. Sinus trouble | Yes | No |
| f. Asthma | Yes | No |
| g. Fainting spells or seizures | Yes | No |
| h. Diabetes | Yes | No |
| i. Hepatitis, jaundice or liver disease | Yes | No |
| j. Frequent or recurring mouth sores | Yes | No |
| k. Thyroid problems | Yes | No |
| l. Respiratory problems, emphysema, bronchitis, COPD ,etc. | Yes | No |
| m. Arthritis or painful, swollen joints including jaw joint (TMJ) | Yes | No |
| n. Osteoporosis | Yes | No |
| o. Stomach ulcer or colitis | Yes | No |
| p. Kidney disease | Yes | No |
| q. Tuberculosis | Yes | No |
| r. Persistent cough or cough that produces blood | Yes | No |
| s. Persistent swollen neck glands | Yes | No |



- | | | |
|--|-----|----|
| t. Low blood pressure | Yes | No |
| u. Epilepsy or neurological disorder | Yes | No |
| v. Cancer | Yes | No |
| w. Any disease, drug or transplant operation that has depressed your immune system | Yes | No |
| 11. Have you had abnormal bleeding? | Yes | No |
| a. Have you ever required a blood transfusion? | Yes | No |
| 12. Do you have any blood disorder such as anemia? | Yes | No |
| 13. Have you ever had treatment for a tumor or growth? | Yes | No |
| 14. Have you had radiation therapy to the head, neck or jaws? | Yes | No |
| 15. Are you allergic to or have you had a reaction to: | | |
| a. Local anesthetics | Yes | No |
| b. Penicillin or antibiotics | Yes | No |
| c. Sulfa drugs | Yes | No |
| d. Barbiturates or sleeping pills | Yes | No |
| e. Aspirin..... | Yes | No |
| f. Iodine | Yes | No |
| g. Codeine or other narcotics | Yes | No |
| h. Latex or rubber products | Yes | No |
| i. Other (<i>please list name of medication</i>) | Yes | No |
| 16. Have you had any serious trouble associated with previous dental treatment? | Yes | No |
| If so, explain _____ | | |
| 17. Do you have any other condition or disease you think the doctor should know about? | Yes | No |
| If so, explain _____ | | |
| 18. Do you smoke or chew Tobacco? | Yes | No |
| How much? _____ How long ? _____ | | |
| 19. Is there any past history of alcohol or chemical dependency or emotional disorder that may affect the care we provide you? | Yes | No |
| 20. Are you wearing contact lenses? | Yes | No |
| 21. Are you wearing removable dental appliances? | Yes | No |
| 22. Do you wish to talk with the doctor privately about anything? | Yes | No |

Women

- | | | |
|---|-----|----|
| Are you pregnant or any chance you might be pregnant? | Yes | No |
| Are you nursing? | Yes | No |
| Are you taking birth control pills? (If so, antibiotics and some other medications may interfere with the effectiveness of birth control. Consult with your physician.) | Yes | No |

Chief Dental Complaint

I have read and understand the above. Any questions I had about this form have been answered and I understand the answers. I understand it is my responsibility to fill out the form correctly and completely.

Patient's Signature _____ Date _____