

# MEDICAL HISTORY QUESTIONNAIRE

## MEDICAL ALERT:

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

\_\_\_\_\_

DATE OF BIRTH (DAY/MONTH/YEAR):     /     /

ADDRESS (HOME):

\_\_\_\_\_

PHONE:

ADDRESS (BUSINESS):

\_\_\_\_\_

PHONE:

OCCUPATION:

WHO REFERRED YOU TO OUR OFFICE?

\_\_\_\_\_

## IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

DAY-TIME PHONE: \_\_\_\_\_

NAME OF FAMILY DOCTOR: \_\_\_\_\_

PHONE OR ADDRESS: \_\_\_\_\_

\_\_\_\_\_

(1) NAME OF MEDICAL SPECIALIST: \_\_\_\_\_

AREA OF SPECIALITY: \_\_\_\_\_

PHONE OR ADDRESS: \_\_\_\_\_

(2) NAME OF MEDICAL SPECIALIST: \_\_\_\_\_

AREA OF SPECIALITY: \_\_\_\_\_

PHONE OR ADDRESS: \_\_\_\_\_

**The following information is required to enable us to provide you with the best possible dental care. 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 condition at the present or have you been treated within the past year? If so, why?  
 YES     NO     NOT SURE/MAYBE

2. When was your last medical checkup?  
\_\_\_\_\_

3. Has there been any change in your general health in the past year? If yes, please explain.  
 YES     NO     NOT SURE/MAYBE

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list.  
 YES     NO     NOT SURE/MAYBE

5. 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. hayfever, foods

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.  
 YES     NO     NOT SURE/MAYBE

7. Do you have or have you ever had asthma?  YES  NO  NOT SURE/MAYBE
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8. Do you have or have you ever had any heart or blood pressure problems?  YES  NO  NOT SURE/MAYBE
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9. Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever?  YES  NO  NOT SURE/MAYBE
- 
10. Do you have a prosthetic or artificial joint?  YES  NO  NOT SURE/MAYBE
- 
11. Have you ever been advised by your doctor to take antibiotics before dental treatment?  YES  NO  NOT SURE/MAYBE
- 
12. Do you have any conditions or therapies that could affect your immune system e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy?  YES  NO  NOT SURE/MAYBE
- 
13. Have you ever had hepatitis, jaundice or liver disease?  YES  NO  NOT SURE/MAYBE
- 
14. Do you have a bleeding problem or bleeding disorder?  YES  NO  NOT SURE/MAYBE
- 
15. Have you ever been hospitalized for any illnesses or operations? If yes, please explain.  YES  NO  NOT SURE/MAYBE
- 

16. Do you have or have you ever had any of the following? Please check.

- |   |   |                                       |  |  |  |
|---|---|---------------------------------------|--|--|--|
| <input type="checkbox"/> chest pain, angina | <input type="checkbox"/> shortness of breath    | <input type="checkbox"/> pacemaker    | <input type="checkbox"/> steroid therapy | <input type="checkbox"/> seizures (epilepsy) | <input type="checkbox"/> drug/alcohol dependency |
| <input type="checkbox"/> heart attack       |   | <input type="checkbox"/> lung disease | <input type="checkbox"/> diabetes        | <input type="checkbox"/> kidney disease      |  |
| <input type="checkbox"/> stroke             | <input type="checkbox"/> prosthetic heart valve | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> stomach ulcers  | <input type="checkbox"/> thyroid disease     |  |
|   |   | <input type="checkbox"/> cancer       | <input type="checkbox"/> arthritis       | <input type="checkbox"/> diet pill therapy   |  |
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17. Are there any conditions or diseases not listed above that you have or have had? If so, what?  YES  NO  NOT SURE/MAYBE

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18. Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease)  YES  NO  NOT SURE/MAYBE

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19. Do you smoke or chew tobacco products?  YES  NO  NOT SURE/MAYBE

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20. Are you nervous during dental treatment?  YES  NO  NOT SURE/MAYBE

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21. **For women only:** Are you breast-feeding or pregnant? If pregnant, what is the expected delivery date?  YES  NO  NOT SURE/MAYBE

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**To the best of my knowledge, the above information is correct:**

PATIENT/PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

DENTIST SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

DENTIST'S NOTES