MEDICAL HISTORY QUESTIONNAIRE

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. Please fill in entire form.

1. Are you being treated for any medial 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

1. _____ 2._____
3. _____ 4._____
5. _____ 6._____

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, metals _____

_____

6. Do you have an adverse skin reaction when wearing jewelry?
☐Yes ☐No ☐Not Sure/Maybe

_____

7. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.
☐Yes ☐No ☐Not Sure/Maybe

_____

8. Do you have or have you ever had asthma?☐Yes ☐No ☐Not Sure/Maybe

_____

9. Do you have or have you ever had any heart or blood pressure problems?
☐Yes ☐No ☐Not Sure/Maybe

_____

10. Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congential heart disease) or a heart transplant? ☐Yes ☐No ☐Not Sure/Maybe

_____

11. Do you have a prosthetic or artificial joint? (hip, knee, etc.)
☐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.

☐chest pain, angina	☐rheumatic fever	☐pacemaker	☐steriod therapy
☐seizures (epilepsy)	☐osteoporosis	☐heart attack	☐mitral valve
☐lung disease	☐diabetes	☐kidney disease	☐stroke
☐prolapse	☐tuberculosis	☐stomach ulcers	☐thyroid disease
☐shortness of breathe	☐heart murmer	☐cancer	☐arthritis

☐drug/alcohol dependency

17. Are there any conditions or diseases not listed above that you have or have had? If so, what? ☐Yes ☐No ☐Not Sure/Maybe

_____

18. Are there any diseases or medical problems that run in your family? (e.g. diabetes, heart disease)
☐Yes ☐No ☐Not Sure/Maybe

_____

19. Do you smoke or chew tobacco products? ☐Yes ☐No ☐Not Sure/Maybe

_____

20. For woman only Are you breastfeeding or possibly pregnant? If pregnant, what is the expected delivery date? ☐Yes ☐No ☐Not Sure/Maybe

_____