Medical History Questionnaire

MEDICAL ALERT:

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

DATE OF BIRTH (DAY/MONTH/YEAR):

ADDRESS (HOME):

**IN CASE OF EMERGENCY, WE SHOULD NOTIFY:**

NAME: RELATIONSHIP: DAY-TIME PHONE: NAME OF FAMILY DOCTOR: PHONE OR ADDRESS:

PHONE:

EMAIL:

OCCUPATION:

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 currently being treated for any medical condition, or have you been treated within the past year? 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 them. Yes No Not Sure/Maybe
5. Do you have any allergies? If yes, please list them using the categories below:

Yes No

Not Sure/Maybe

1. medications
2. latex/rubber products
3. other (e.g. hay fever, seasonal/environmental, foods)
4. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain. Yes No Not Sure/Maybe
5. Do you have or have you ever had asthma?

Yes No

Not Sure/Maybe

1. Do you have or have you ever had any heart or blood pressure problems?

Yes No

Not Sure/Maybe

1. 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. congenital heart disease) or a heart transplant? Yes No Not Sure/Maybe

1. Do you have a prosthetic or artificial joint?

Yes No

Not Sure/Maybe

1. 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
2. Have you ever had hepatitis, jaundice or liver disease?

Yes No

Not Sure/Maybe

1. Do you have a bleeding problem or bleeding disorder?

Yes No

Not Sure/Maybe

1. Have you ever been hospitalized for any illnesses or operations? If yes, please explain. Yes No Not Sure/Maybe
2. Do you have or have you ever had any of the following? Please check.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| chest pain, angina | rheumatic fever | pacemaker | steroid therapy | seizures (epilepsy) |
| heart attack | mitral valve prolapse | lung disease | diabetes | kidney disease |
| stroke, TIA | tuberculosis | stomach ulcers | thyroid disease | shortness of breath |
| heart murmur | cancer | arthritis | dependency of drug/alcohol/cannabis | osteoporosis medications(e.g. Fosamax, Actonel) |

1. Are there any conditions or diseases not listed above that you have or have had? If yes, please explain. Yes No Not Sure/Maybe
2. Are there any diseases or medical problems that run in your family (e.g. diabetes, cancer or heart disease)? Yes No Not Sure/Maybe
3. Do you smoke or chew tobacco products?

Yes No

Not Sure/Maybe

1. Are you nervous during dental treatment?

Yes No

Not Sure/Maybe

1. Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date? Yes No Not Sure/Maybe
2. Do you identify as a patient with a disability? If yes, please explain.

Yes No

Not Sure/Maybe

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

Patient/Parent/Guardian Signature: Date:

Dentist Signature: Date:

DENTIST’S NOTES: **Blood Pressure:**

 **Pulse:**