

# 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 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
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10. Do you have a prosthetic or artificial joint?  YES  NO  NOT SURE/MAYBE
- 
11. 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
- 
12. Have you ever had hepatitis, jaundice or liver disease?  YES  NO  NOT SURE/MAYBE
- 
13. Do you have a bleeding problem or bleeding disorder?  YES  NO  NOT SURE/MAYBE
- 
14. Have you ever been hospitalized for any illnesses or operations? If yes, please explain.  YES  NO  NOT SURE/MAYBE
- 

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

- |  |  |                                       |  |  |   |
|--|--|---------------------------------------|--|--|---|
| <input type="checkbox"/> chest pain, angina  | <input type="checkbox"/> rheumatic fever       | <input type="checkbox"/> pacemaker    | <input type="checkbox"/> steroid therapy | <input type="checkbox"/> seizures (epilepsy)     | <input type="checkbox"/> osteoporosis medications |
| <input type="checkbox"/> heart attack        | <input type="checkbox"/> mitral valve prolapse | <input type="checkbox"/> lung disease | <input type="checkbox"/> diabetes        | <input type="checkbox"/> kidney disease          | (e.g. Fosamax, Actonel)                           |
| <input type="checkbox"/> stroke              | <input type="checkbox"/> heart murmur          | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> stomach ulcers  | <input type="checkbox"/> thyroid disease         |   |
| <input type="checkbox"/> shortness of breath |  | <input type="checkbox"/> cancer       | <input type="checkbox"/> arthritis       | <input type="checkbox"/> drug/alcohol dependency |   |
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16. 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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17. 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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18. Do you smoke or chew tobacco products?  YES  NO  NOT SURE/MAYBE

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

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20. **For women only:** Are you breastfeeding 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