

# 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 currently being treated for any medical condition or have you been treated within the past year? If yes, please explain?     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  
a) medications \_\_\_\_\_  
b) latex/rubber products \_\_\_\_\_  
c) other (e.g. hay fever, seasonal/environmental, 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

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

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

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

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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"/> heart attack       | <input type="checkbox"/> mitral valve prolapse | <input type="checkbox"/> lung disease   | <input type="checkbox"/> diabetes                                | <input type="checkbox"/> kidney disease                                   |
| <input type="checkbox"/> stroke, TIA        | <input type="checkbox"/> tuberculosis          | <input type="checkbox"/> stomach ulcers | <input type="checkbox"/> thyroid disease                         | <input type="checkbox"/> shortness of breath                              |
| <input type="checkbox"/> heart murmur       | <input type="checkbox"/> cancer                | <input type="checkbox"/> arthritis      | <input type="checkbox"/> drug/alcohol/cannabis use or dependency | <input type="checkbox"/> osteoporosis medications (e.g. Fosamax, Actonel) |

16. Are there any conditions or diseases not listed above that you have or have had? If yes, please explain.  
 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

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

19. Are you nervous during dental treatment?  Yes  No  Not Sure/Maybe

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

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21. Do you identify as a patient with a disability? If yes, please explain.  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: