

Medical History Questionnaire

MEDICAL ALERT:

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

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

ADDRESS (HOME):

PHONE (HOME): PHONE (MOBILE):

EMAIL:

HOW DID YOU HEAR ABOUT US?

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME / RELATIONSHIP:

DAY-TIME PHONE:

NAME OF FAMILY DOCTOR:

PHONE OR ADDRESS:

INSURANCE COMPANY:

POLICY/ GROUP/ CONTRACT #:

CERTIFICATE/ ID #:

SUBSCRIBER'S NAME:

SUBSCRIBER'S DATE OF BIRTH (DAY/MONTH/YEAR): / /

RELATIONSHIP TO SUBSCRIBER:

SECONDARY INSURANCE COMPANY:

POLICY/ GROUP/ CONTRACT #:

CERTIFICATE/ ID #:

SUBSCRIBER'S NAME:

SUBSCRIBER'S DATE OF BIRTH (DAY/MONTH/YEAR): / /

RELATIONSHIP TO SUBSCRIBER:

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

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

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

21. 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:

Dental History Questionnaire

Name: MR./MISS/MRS./MS./DR. _____

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. What is the reason for your visit today? Are you currently experiencing any dental problems?

2. Have you been seeing a dentist regularly? If not, why not? Yes No

3. Are you nervous during dental visits? Yes No Not Sure/Maybe

4. Have you had a bad experience or complications during dental treatment? Yes No Not Sure/Maybe

5. When was your last dental visit? What was done at that appointment?

6. When did you last have dental x-rays?

7. Have you ever seen a dental specialist? Yes No Not Sure/Maybe

8. How often do you brush your teeth? How often do you floss? Do your gums bleed when you brush or floss?

9. Have you been told to take antibiotics before a dental appointment? Yes No Not Sure/Maybe

10. Do you feel that you have bad breath? Yes No Not Sure/Maybe

11. Are you happy with the appearance of your teeth? Yes No Not Sure/Maybe

12. Do you have any problems with your jaw (clicking, limited movement, pain)? Yes No Not Sure/Maybe

13. Have you ever had an injury to the teeth or jaws or been involved in a motor vehicle accident?
 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: