

# Medical Health Questionnaire

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Patient's Physician: \_\_\_\_\_ City: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of Last Medical Visit: \_\_\_\_\_

Are you currently under a physician's care now?  No  Yes, for \_\_\_\_\_

Have you ever been hospitalized or had surgery in the past two years?  No  Yes, for \_\_\_\_\_

Have you ever had a serious illness?  No  Yes If yes, what? \_\_\_\_\_

**Please list all pills, medications, herbs, and drugs that have been prescribed for you and ALL others that you take:**

\_\_\_\_\_

**Are you taking any bisphosphonate or bone sparing drugs? (Fosamax, Actonel, Boniva, Didronel)  No  Yes**

**Do you have any allergies or reactions to drugs/medications, anesthetics, latex, or certain metals?  No  Yes:**

**If yes please list all**

\_\_\_\_\_

Do you: Use tobacco?  No  Yes \_\_\_\_\_ /day Drink alcoholic beverages?  No  Yes amount/day \_\_\_\_\_

**Women:** Are you: Pregnant/Possibly Pregnant?  No  Yes Breastfeeding?  No  Yes Taking birth control pills?  No  Yes

## DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Adrenal Disease          | <input type="checkbox"/> Convulsion                  | <input type="checkbox"/> <u>Heart Surgery</u>     | <input type="checkbox"/> <u>Mitral Valve Prolapse</u> |
| <input type="checkbox"/> AIDS/HIV+/ARC            | <input type="checkbox"/> Cortisone/Steroids          | <input type="checkbox"/> Hemophilia               | <input type="checkbox"/> Mental Difficulties          |
| <input type="checkbox"/> Alzheimer's              | <input type="checkbox"/> <u>Diabetes</u>             | <input type="checkbox"/> Hepatitis                | <input type="checkbox"/> <u>Neck/Back Pain</u>        |
| <input type="checkbox"/> Anaphylaxis              | <input type="checkbox"/> Drug/Alcohol Abuse          | <input type="checkbox"/> Herpes                   | <input type="checkbox"/> Parathyroid Disease          |
| <input type="checkbox"/> Anemia                   | <input type="checkbox"/> Emphysema                   | <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Persistent Cough             |
| <input type="checkbox"/> <u>Angina</u>            | <input type="checkbox"/> <u>Endocarditis</u>         | <input type="checkbox"/> Hives/Rash               | <input type="checkbox"/> Psychiatric Care             |
| <input type="checkbox"/> Arthritis                | <input type="checkbox"/> Enlarged Heart              | <input type="checkbox"/> <u>Immunosuppression</u> | <input type="checkbox"/> Radiation Therapy            |
| <input type="checkbox"/> <u>Artificial Joints</u> | <input type="checkbox"/> Epilepsy/Seizures           | <input type="checkbox"/> Intestinal Disease       | <input type="checkbox"/> Renal Dialysis               |
| <input type="checkbox"/> <u>Artificial Valves</u> | <input type="checkbox"/> Excessive Bleeding          | <input type="checkbox"/> Irregular Heart Beat     | <input type="checkbox"/> Rheumatic Fever              |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Fainting/Dizziness          | <input type="checkbox"/> Jaundice                 | <input type="checkbox"/> Sinus Problems               |
| <input type="checkbox"/> Blood Disease            | <input type="checkbox"/> Glaucoma                    | <input type="checkbox"/> Joint Pain/Swelling      | <input type="checkbox"/> Stomach Problems             |
| <input type="checkbox"/> Bruise Easily            | <input type="checkbox"/> Gout                        | <input type="checkbox"/> Kidney Problems          | <input type="checkbox"/> Stroke                       |
| <input type="checkbox"/> Cancer                   | <input type="checkbox"/> <u>Heart Abnormality</u>    | <input type="checkbox"/> Leukemia                 | <input type="checkbox"/> Thyroid Disease              |
| <input type="checkbox"/> Chemotherapy             | <input type="checkbox"/> <u>Heart Attack/Failure</u> | <input type="checkbox"/> Liver Disease            | <input type="checkbox"/> TMJ Problems                 |
| <input type="checkbox"/> Chest Pain               | <input type="checkbox"/> <u>Heart Murmur</u>         | <input type="checkbox"/> Low Blood Pressure       | <input type="checkbox"/> Tuberculosis                 |
| <input type="checkbox"/> Cold Sores               | <input type="checkbox"/> <u>Heart Pacemaker</u>      | <input type="checkbox"/> Lung Disease             | <input type="checkbox"/> Tumors/Growths               |
| <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Heart Problems              | <input type="checkbox"/> <u>Lupus</u>             | <input type="checkbox"/> Ulcers                       |

**Have you ever been directed to take antibiotics prior to any dental treatment?  No  Yes**

Do you have any problem, condition or disease not listed above?  No  Yes If so, what?

\_\_\_\_\_

To the best of my knowledge, the questions on this form have been answered accurately. I understand that withholding or providing incorrect information may be dangerous to my (or the patient's) health. I also agree to inform the doctor and/or staff of any changes in my (or the patient's) medical status.