## MEDICAL HISTORY QUESTIONNAIRE

## MEDICAL ALERT:

NAME: MR./MISS/MRS./MS./DR.	IN CASE OF EMERGENCY, WE S	IN CASE OF EMERGENCY, WE SHOULD NOTIFY:				
	NAME:					
DATE OF BIRTH (DAY/MONTH/YEAR): / /	RELATIONSHIP:					
ADDRESS (HOME):	DAY-TIME PHONE:					
	NAME OF FAMILY DOCTOR:					
	PHONE OR ADDRESS:					
PHONE:						
ADDRESS (BUSINESS):						
	(1) NAME OF MEDICAL SPECIALIS	T:				
	AREA OF SPECIALITY:					
PHONE:	PHONE OR ADDRESS:					
OCCUPATION:	(2) NAME OF MEDICAL SPECIALIS	T:				
WHO REFERRED YOU TO OUR OFFICE?	AREA OF SPECIALITY:					
	PHONE OR ADDRESS:					
1. Are you being treated for any medical condition a	☐ YES	□NO	□ NOT SURE/MAYBE			
2. When was your last medical checkup?						
3. Has there been any change in your general health in	n the past year? If yes, please explain.					
	☐ YES	□NO	□ NOT SURE/MAYBE			
<b>4.</b> Are you taking any medications, non-prescription	drugs or herbal supplements of any kind? If		e list.			
	☐ YES	□ио	□ NOT SURE/MAYBE			
<b>5.</b> Do you have any allergies? If you answered yes, p						
a) medications b) latex/rubber products	☐ YES	□ NO	□ NOT SURE/MAYBE			
c) other (e.g. hayfever, foods)						
<b>6.</b> Have you ever had a peculiar or adverse reaction to	o any medicines or injections? If yes, please ex	mlain				
21 jou and make a peculial of date see redelion to	□ YES	.piairi. □ NO	☐ NOT SURE/MAYBE			

7. Do you have or have you ever had asthma?					□NO	☐ NOT SURE/MAYBE
8. Do you have or have you ever had any heart or blood pressure problems?					□NO	☐ NOT SURE/MAYBE
_	ve you ever had a replant when the very more very more very more very very very very very very very ve		a heart valve, an infecti eart transplant?	on of the	heart (i.e. ir	nfective endocarditis),
10. Do you have a prosthetic or artificial joint?					□ NO	☐ NOT SURE/MAYBE
<b>11.</b> Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy?					□ NO	☐ NOT SURE/MAYBE
12. Have you ever had hepatitis, jaundice or liver disease?					□NO	☐ NOT SURE/MAYBE
13. Do you have a bleeding problem or bleeding disorder?					□NO	☐ NOT SURE/MAYBE
<b>14.</b> Have you ever bee	n hospitalized for any i	llnesses or operations	? If yes, please explain.	☐ YES	□ NO	☐ NOT SURE/MAYBE
15. Do you have or h	ave you ever had any	of the following? Plea	ase check.			
<ul><li>□ chest pain, angina</li><li>□ heart attack</li><li>□ stroke</li><li>□ shortness of breath</li></ul>	☐ rheumatic fever ☐ mitral valve prolapse ☐ heart murmur	☐ pacemaker☐ lung disease☐ tuberculosis☐ cancer☐	☐ steroid therapy☐ diabetes☐ stomach ulcers☐ arthritis☐	□ seizures (epilepsy) □ kidney disease □ thyroid disease □ drug/alcohol dependency □ seizures (epilepsy) □ osteoporosis medications (e.g. Fosama: Actonel)		
<b>16.</b> Are there any con	nditions or diseases no	t listed above that yo	u have or have had? If	so, what	? ••• NO	☐ NOT SURE/MAYBE
<b>17.</b> Are there any dise (e.g. diabetes, cancer	eases or medical proble or heart disease)	ems that run in your f	amily?	☐ YES	□ NO	□ NOT SURE/MAYBE
18. Do you smoke or chew tobacco products?					□NO	☐ NOT SURE/MAYBE
19. Are you nervous during dental treatment?					□ NO	☐ NOT SURE/MAYBE
20. For women only	<b>/:</b> Are you breastfeedir	ng or pregnant? If pre	egnant, what is the exp	pected del	ivery date? □ NO	□ NOT SURE/MAYBE
To the best of my k	nowledge, the abov	e information is co	rrect:			
PATIENT/PARENT/GUARDI	AN SIGNATURE:		DAT	ſE:		
DENTIST SIGNATURE:			DA	ſE:		

DENTIST'S NOTES