MEDICAL QUESTIONNAIRE

Please answer all questions and fill in blank spaces where indicated. Answers to the following questions are for our records only and will be strictly confidential.

MEDICAL HISTORY FOR:(NAME OF PATIENT) ____________________

01. Do you have a personal physician? ( ) Yes ( ) No Date of last visit: ____________
    Physician's Name: ____________________ Phone #: ____________
02. Are you currently under the care of a physician? ( ) Yes ( ) No
    Please Explain: ____________________
03. Do you have any metal rods, pins or implants? ( ) Yes ( ) No
04. Are you taking any prescription / over-the-counter drugs? ( ) Yes ( ) No
    Please list each one:
05. Do you have or have you had any of the following diseases or problems? (Please check "Y" for Yes or "N" for No)

( )Yes ( )No Abnormal Bleeding
( )Yes ( )No AIDS
( )Yes ( )No Alcohol / Drug Abuse
( )Yes ( )No Anemia
( )Yes ( )No Arthritis
( )Yes ( )No Artificial Bones/Joints/Valves
( )Yes ( )No Blood Transfusion
( )Yes ( )No Cancer / Chemotherapy
( )Yes ( )No Colitis
( )Yes ( )No Congenital Heart Defect
( )Yes ( )No Diabetes
( )Yes ( )No Difficulty Breathing
( )Yes ( )No Emphysema
( )Yes ( )No Epilepsy / Seizures
( )Yes ( )No Fainting Spells
( )Yes ( )No Frequent Headaches
( )Yes ( )No Glaucoma
( )Yes ( )No Hay Fever
( )Yes ( )No Heart Attack / Surgery
( )Yes ( )No Heart Murmur
( )Yes ( )No Hepatitis
( )Yes ( )No Herpes / Fever Blisters
( )Yes ( )No High Blood Pressure
( )Yes ( )No Hospitalized for Any Reason
( )Yes ( )No Kidney Problems
( )Yes ( )No Liver Disease
( )Yes ( )No Low Blood Pressure
( )Yes ( )No Pacemaker
( )Yes ( )No Psychiatric Problems
( )Yes ( )No Radiation / Therapy
( )Yes ( )No Rheumatic / Scarlet Fever
( )Yes ( )No Seizures
( )Yes ( )No Shingles
( )Yes ( )No Sickle Cell Disease / Traits
( )Yes ( )No Sinus Problems
( )Yes ( )No Stroke
( )Yes ( )No Thyroid Problems
( )Yes ( )No Tuberculosis (TB)
( )Yes ( )No Ulcers
( )Yes ( )No Venereal Disease
( )Yes ( )No I smoke / use chewing tobacco

Women
( )Yes ( )No Are you taking birth control
( )Yes ( )No Are you pregnant?
Week #: ____________
( )Yes ( )No Are you nursing?
Other ____________

06. Anything you would like to discuss with the dentist in private? ( )Yes ( )No
    Please list any serious medical condition(s) that you have ever had: ____________________
    ____
07. Are you allergic to any of the following:

( )Yes ( )No Aspirin
( )Yes ( )No Codeine
( )Yes ( )No Dental Anesthetics
( )Yes ( )No Erythromycin
( )Yes ( )No Jewelry / Metals
( )Yes ( )No Latex
( )Yes ( )No Penicillin
( )Yes ( )No Tetracycline

Please list any drugs / materials that you are allergic to: ____________________

IN CASE OF EMERGENCY:

Name Of Contact: ____________________ Phone Number: ____________
Name Of Contact: ____________________ Phone Number: ____________

DENTAL HISTORY:

01. Why have you come to the dentist today? ____________________
02. Your current dental health is ( ) Good ( ) Fair ( ) Poor
03. Does any of the following apply? (Please check "Y" for Yes or "N" for No)

( )Yes ( )No Have you ever taken Phen – Phen / Redux & Pondimin?
If Yes, When? ____________________
( )Yes ( )No Do You require antibiotics before dental treatment?
( )Yes ( )No Are you currently in pain?
( )Yes ( )No Have you ever had gum treatment?
( )Yes ( )No Have you ever had problem with any previous dental work?
( )Yes ( )No Have you ever experienced pain / discomfort in your law joint-TMJ?
( )Yes ( )No Do your gums ever bleed?
( )Yes ( )No Are your teeth sensitive to heat, cold, or anything else?
( )Yes ( )No Do you like your smile?

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

PATIENT'S SIGNATURE: ____________________ DATE: ____________
DOCTOR'S SIGNATURE: ____________________ DATE: ____________