

PATIENT MEDICAL QUESTIONNAIRE

NAME _____ BIRTHDATE _____ TODAY'S DATE _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

What is your main concern for seeking dental treatment at this time?

1. Are you in good health? yes no

2. Have there been any changes in your general health within the past year? yes no

3. Date of your last physical exam? _____

4. Physician's name _____

Address _____

Phone number _____

5. Are you now under the care of a physician? yes no

6. Have you been hospitalized for any surgical operation or serious illness? yes no
 Please explain _____

7. Are you taking any medication? Including non-prescription medications? yes no
 If yes, what medications are you taking? _____

8. Have you had any abnormal bleeding or do you bruise easily? yes no

9. Do you smoke? yes no
 If yes, # Packs per day? _____ Years? _____

10. Do you use chewing tobacco? yes no

11. Do you use alcohol? yes no

12. Do you use cocaine or other drugs? yes no

13. Are you allergic to or have had reactions to:
 Local anesthetics? yes no
 Penicillin or antibiotics? yes no
 Barbiturates, sedative yes no
 Aspirin? yes no
 Latex? yes no
 Other? _____ yes no

14. Have you ever required or been told that you require an antibiotic medication prior to dental treatment? yes no

a. Do you have a heart murmur, heart defect, or valve replacement? yes no

b. Do you have a joint replacement or implant? yes no

c. Have you ever had rheumatic fever or rheumatic heart disease? yes no

d. Have you ever been treated for SBE? yes no

15. Do you have or have you ever had:
 Heart trouble, heart attack, or angina? yes no
 Pacemaker? yes no
 Heart surgery? yes no
 High blood pressure? yes no
 Date _____ / _____
 Low blood pressure yes no
 Hepatitis, jaundice, liver disease? yes no
 Stroke? yes no
 Sinus trouble? yes no
 Asthma? yes no
 Seizures? yes no
 Diabetes? yes no
 AIDS or HIV? yes no
 Stomach ulcer? yes no
 Tuberculosis? yes no
 Cancer? yes no
 Epilepsy? yes no
 Glaucoma? yes no

16. Do you have any disease, condition, or problem not listed that you feel we should know about?

WOMEN ONLY:

18. Are you pregnant or think that you maybe pregnant? yes no
 19. Are you nursing? yes no
 20. Are you taking birth control pills/patch? yes no

I certify that the information listed is complete and accurate.

 Patient, Parent, or Guardian Signature