Medical History Questionnaire

Name: _____

Please answer all questions below by checking a box under YES or NO.
Your responses will be held strictly confidential and will only be used to help assess your medical condition.
If you have any hesitations, please express your concern to a member of our team.

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

Cardiovascular:

YES	NO	
☐	☐	High Blood Pressure
☐	☐	Heart Disease from Childhood
☐	☐	Heart Murmur
☐	☐	Rheumatic Fever
☐	☐	Use of Phen-Fen
☐	☐	Pacemaker
☐	☐	Vascular Graft
☐	☐	Heart Valve Replacement
☐	☐	Heart Attack
☐	☐	Heart Surgery
☐	☐	Congestive Heart Failure
☐	☐	Angina (Chest Pain)
☐	☐	Irregular Heart Beat
☐	☐	Stroke

Respiratory:

YES	NO	
☐	☐	Asthma
☐	☐	Emphysema
☐	☐	Tuberculosis
		Other: _____

Musculo-Skeletal/CNS/Developmental:

YES	NO	
☐	☐	Joint Replacement (Surgery Date_____)
☐	☐	Osteoarthritis
☐	☐	Rheumatoid Arthritis
☐	☐	Spinal Cord Injury
☐	☐	Seizures
☐	☐	Cerebral Palsy
☐	☐	Intellectual Disability
☐	☐	Dementia
☐	☐	Osteoporosis
☐	☐	Hormone Replacement: IV or Oral

Endocrine/Hematologic/Oncologic/Immune:

YES	NO	
☐	☐	Diabetes
☐	☐	Thyroid Disease
☐	☐	Hemophilia
☐	☐	Sickle Cell Disease
☐	☐	Bleeding Tendency
☐	☐	Anemia
☐	☐	Cancer
☐	☐	Radiation Therapy
☐	☐	Chemotherapy
☐	☐	HIV Infection/AIDS
☐	☐	Organ Transplant
☐	☐	Blood Transfusion (What year? _____)

Psychological:

YES	NO	
☐	☐	Anxiety/Nervousness
☐	☐	Depression
☐	☐	Mental Health Treatment
☐	☐	Eating Disorder

Gastrointestinal (GI) & Genitourinary (GU):

YES	NO	
☐	☐	Hepatitis (A, B, C, or other?)
☐	☐	Kidney Dialysis
☐	☐	Ulcers
☐	☐	Sexually Transmitted Disease
☐	☐	Denied permission to give blood

Social:

YES	NO	
☐	☐	Do you use tobacco products? If so, what kind? _____ How much/How often?) _____
☐	☐	Do you drink alcohol? If so, how frequently? _____
☐	☐	Do you use recreational drugs?

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Medical Allergy or Intolerance:

YES or NO

- ☐ ☐ Penicillin
- ☐ ☐ Dental Anesthetic ("Novocain")
- ☐ ☐ Codeine
- ☐ ☐ Latex Products
- ☐ ☐ Epinephrine
- ☐ ☐ Food Allergies

If so, what kind(s)? _____

Other: _____

Surgical History:

_____

_____

_____

_____

Medications:

YES or NO

- ☐ ☐ Are you taking any prescription medicine now?
- ☐ ☐ Are you taking any over-the-counter medicine now?
- ☐ ☐ Are you taking any herbal medications now?

For any YES answer above, please list name, dose, and regimen in the chart below.

☐ ☐ Are you or have you ever taken Biphospho nates? Oral _____ I.V. _____

If Yes, for how long: _____

___ Actonel __Aredia __Boniva __ Didronel __Fosamax __ Skelif __ Zometa

Medications: • Prescribed • Over-the-Counter • Herbal	**Condition for which it is used**	**Dose**	**Regimen**	**Other**

When was your last medical check-up? Date: _____

Family: Did a parent, sibling, or a child of yours have any of the following?

YES or NO

- ☐ ☐ Diabetes
- ☐ ☐ High Blood Pressure
- ☐ ☐ Heart Disease
- ☐ ☐ Bleeding Tendency

Females:

YES or NO

- ☐ ☐ Are you pregnant now?

If so, how many months? _____

- ☐ ☐ Do you take birth control pills?
- ☐ ☐ Are you breastfeeding now?

Do you have:

YES or NO

- ☐ ☐ Frequent Hunger
- ☐ ☐ Frequent Thirst
- ☐ ☐ Night Sweats
- ☐ ☐ Fainting Spells
- ☐ ☐ Visual Impairment
- ☐ ☐ Glaucoma
- ☐ ☐ Hearing Impairment

Do you have any medical conditions that are not already mentioned?

_____

_____

_____

To the best of my knowledge, all of the preceding answers are true. If I have any change in my health status, or change in any medicines, I will inform my dental health care provider at my next appointment.

_____ _____

Signature of patient (Parent or Guardian if patient is under 18) Date

Dental History Questionnaire

Name: _____

What is the primary reason for your visit today?

_____

_____

What would you like to change in your smile?

_____

_____

Pain History: Do you have any of the following?

YES or **NO**

- ☐ ☐ Oral pain now?
- ☐ ☐ Chronic oral-facial or headache pain?
- ☐ ☐ Pain when you open or close your mouth?
- ☐ ☐ Popping or clicking in your jaw?
- ☐ ☐ Do you grind/clench your teeth?

Saliva:

YES or **NO**

- ☐ ☐ Does the amount of saliva in your mouth seem to be too little?
- ☐ ☐ Does your mouth feel dry when eating a meal?

Dental Treatment History:

When was the date of your last dental visit? _____

What treatment was rendered at that visit? _____

Periodontal Disease History:

YES or **NO**

- ☐ ☐ Have you ever been told that you have periodontal (gum) disease?
- ☐ ☐ Do your gums bleed?
- ☐ ☐ Have you noticed your gums receding?
- ☐ ☐ Have you ever received treatment for periodontal (gum) disease?

If so, what type and when?

- ☐ Scaling and Root Planing (Deep Cleaning): _____
- ☐ Periodontal Surgery: _____
- ☐ Bone Graft: _____
- ☐ Gum Graft: _____
- ☐ Dental Implants: _____

Anxiety:

YES or **NO**

- ☐ ☐ Have you ever had a bad experience at the dental office?

How do you feel about receiving dental treatment?

- ☐ Very relaxed
- ☐ A little uneasy
- ☐ Moderately anxious
- ☐ Very Anxious