MEDICAL QUESTIONNAIRE

NAME: _____ Alert: _____

In order to provide safe dental care for our patients, we are asking you to fill out the following questionnaire. Please answer the questions as accurately as you can. If you have any questions or doubts, check the not sure/maybe choice. Your responses will be reviewed with your by the dentist. You can be assured that the information that you provide will be kept in the strictest confidence.

	Yes	Unsure	No
1. Are you being treated for any medical conditions at the present or have you been treated within the last year?	❑	❑	❑
2. When was your last medical check-up?	❑	❑	❑
3. When was your last visit to a physician?	❑	❑	❑
4. Has there been any changes in your general health in the past year?	❑	❑	❑

Please explain: _____

_____

	Yes	Unsure	No
5. Are you taking any medications or non-prescription drugs of any kind?	❑	❑	❑

If yes please list: _____

_____

6. Do you have any allergies?	❑	❑	❑
7. Have you ever had a peculiar or adverse reaction to any medicines or injections?	❑	❑	❑

Please list. _____

(e.g. Penicillin, aspirin, or local anesthetic, dental freezing) Please list _____

_____

8. Do you have any heart or blood pressure problems?	❑	❑	❑
9. Do you have or have you ever had jaundice, hepatitis or liver disease?	❑	❑	❑
10. Have you ever been told that you should not give blood?	❑	❑	❑
11. Do you have any conditions that could affect your immune system? (e.g. AIDS, HIV positive, leukemia, etc.)	❑	❑	❑
12. Do you have a tendency to bruise easily or bleed for a prolonged period of time after being cut?	❑	❑	❑
13. Have you ever been hospitalized for any serious illnesses or operations?	❑	❑	❑
14. Have you ever been told to take antibiotics before dental work?	❑	❑	❑

15. Do you have or have you ever had any of the following: Please tick off any that apply:

❑ Arthritis	❑ Chest pain	❑ Epilepsy	❑ Pacemaker	❑ Thyroid disease
❑ Asthma	❑ Diabetes	❑ Heart attack	❑ Prosthetic Joint	❑ Tuberculosis
❑ Bronchitis	❑ Diet pill therapy	❑ Kidney disease	❑ Steroid therapy	
❑ Cancer	❑ Emphysema	❑ Lung disease	❑ Stroke	
❑ Crohn's/Ulcerative colitis	❑ Drug/Alcohol dependency	❑ Prosthetic heart valve	❑ Shortness of breath	

	Yes	Unsure	No
16. Are there any conditions of diseases not listed above that you have or have had?	❑	❑	❑

_____

17. Do you smoke or chew tobacco?	❑	❑	❑
18. For Women only – Are you pregnant?	❑	❑	❑

If so, what is the expected delivery date? _____

Follow-up information: _____

_____

_____

To the best of my knowledge, the above information is correct.

Signature of Patient / Parent or Guardian _____ Date _____

Signature of Dentist _____ Date _____