WELCOME TO OUR CLINIC
MEDICAL HISTORY QUESTIONNAIRE

MEDICAL ALERT:

NAME: MR./MISS/MRS./MS./DR.

DATE OF BIRTH (DAY/MONTH/YEAR): / /

ADDRESS (HOME)

PHONE:

ADDRESS (BUSINESS):

PHONE:

OCCUPATION:

WHO REFERRED YOU TO OUR OFFICE?

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME:

RELATIONSHIP:

DAY-TIME PHONE:

NAME OF FAMILY DOCTOR:

PHONE OR ADDRESS:

(1) NAME OF MEDICAL SPECIALIST:

AREA OF SPECIALITY:

PHONE OR ADDRESS:

(2) NAME OF MEDICAL SPECIALIST:

AREA OF SPECIALITY:

PHONE OR ADDRESS:

PRIMARY DENTAL INSURANCE				SECONDARY DENTAL INSURANCE			
Name of Insured:			Date Of Birth: (MMDDYY)	Name of Insured:			Date Of Birth: (MMDDYY)
Employer			Insurance Carrier	Employer			Insurance Carrier
Group/Policy Number	Division	Certificate Number		Group/Policy Number	Division	Certificate Number	
Maximum Benefit Year		Other		Maximum Benefit Year		Other	

1.Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why?
❑YES ❑NO ❑NOT SURE/MAYBE

2. When was your last medical checkup?

3. Has there been any change in your general health in the past year? If yes, please explain.
❑YES ❑NO ❑NOT SURE/MAYBE

4. Are you taking any medications, non-precription drugs or herbal supplements of any kind? If yes, please list.
❑YES ❑NO ❑NOT SURE/MAYBE

MEDICATION LISTING		
Name of Medication:	Reason:	Dosage

5. Do you have any allergies? If you answered yes, please list using the categories below: ❑YES ❑NO ❑NOT SURE/MAYBE

a) medications

b) latex/rubber products

c) other (e.g. hayfever, foods)

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6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain. ❑YES ❑NO ❑NOT SURE/MAYBE

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7. Do you have or have you ever had asthma? ❑YES ❑NO ❑NOT SURE/MAYBE

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8. Do you have or have you ever had any heart or blood pressure problems? ❑YES ❑NO ❑NOT SURE/MAYBE

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9. Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant? ❑YES ❑NO ❑NOT SURE/MAYBE

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10. Do you have a prosthetic or artificial joint? ❑YES ❑NO ❑NOT SURE/MAYBE

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11. Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy? ❑YES ❑NO ❑NOT SURE/MAYBE

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12. Have you ever had hepatitis, jaundice or liver disease? ❑YES ❑NO ❑NOT SURE/MAYBE

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13. Do you have a bleeding problem or bleeding disorder? ❑YES ❑NO ❑NOT SURE/MAYBE

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14. Have you ever been hospitalized for any illnesses or operations? If yes, please explain. ❑YES ❑NO ❑NOT SURE/MAYBE

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15. Do you have or have you ever had any of the following? Please check.

❑ chest pain, angina
❑ heart attack
❑ stroke
❑ shortness of breath
❑ 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
❑ osteoporosis medications (e.g. Fosamax, Actonel)

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16. Are there any conditions or diseases not listed above that you have or have had? If so, what? ❑YES ❑NO ❑NOT SURE/MAYBE

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17. Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease) ❑YES ❑NO ❑NOT SURE/MAYBE

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18. Do you smoke or chew tobacco products? ❑YES ❑NO ❑NOT SURE/MAYBE

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19. Are you nervous during dental treatment? ❑YES ❑NO ❑NOT SURE/MAYBE

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20. **For women only:** Are you breast feeding or pregnant? If pregnant, what is the expected delivery date. ❑YES ❑NO ❑NOT SURE/MAYBE

DENTAL HISTORY				
Reason for Today's Visit:				
How frequently do you see your dentist?: *(Please Circle)* 6 months 9 months Annually When something hurts or breaks				
Former Dentist: Name: Address: Phone:				
Date of your last visit:	Last Cleaning:	Last Examination:		
Are any of your teeth sensitive to?:				
	Cold: Yes No	Hot: Yes No	Sweet: Yes No	Other: Yes No
Do your gums bleed when?:				
	Brushing: Yes No	Flossing: Yes No	Spontaneously: Yes No	
Are you aware or have you been told that you clench or grind your teeth?: Yes No				
Do you have any emotional concerns about your dental visit?: *(Please Circle)* Fear Discomfort Time Cost Embarrassment				
Are you interested in or have you thought about any of the following regarding your teeth?: *(Please Circle)*				
	Orthodontics (Braces)	Tooth Whitening (Bleaching)	Implants	
	Bonding	Crowns (Caps)	Improving your Smile	
	Closing Spaces between Teeth	Sports Mouthguard		
	Replacement of Missing Teeth	Improved Gum Line		
	Repairing Chipped Teeth	Improving Breath Odor		

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

PATIENT/PARENT/GUARDIAN SIGNATURE: **DATE:**

DENTIST SIGNATURE: **DATE:**

DENTIST'S NOTES