



MEDICAL HISTORY QUESTIONNAIRE

MEDICAL ALERT:

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

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

ADDRESS (HOME):

CELL: _____ HOME _____

EMAIL: _____

ADDRESS (BUSINESS):

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 EMAIL ADDRESS _____

(1) NAME OF MEDICAL SPECIALIST _____

AREA OF SPECIALITY _____

PHONE OR ADDRESS _____

(2) NAME OF MEDICAL SPECIALIST _____

AREA OF SPECIALITY _____

PHONE OR ADDRESS _____

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

- 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

- When was your last medical checkup?

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

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

- 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)

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



7. Do you have or have you ever had asthma? YES NO NOT SURE/MAYBE
-
8. Do you have or have you ever had any heart or blood pressure problems? YES NO NOT SURE/MAYBE
-
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
-
10. Do you have a prosthetic or artificial joint? YES NO NOT SURE/MAYBE
-
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
-
12. Have you ever had hepatitis, jaundice or liver disease? YES NO NOT SURE/MAYBE
-
13. Do you have a bleeding problem or bleeding disorder? YES NO NOT SURE/MAYBE
-
14. Have you ever been hospitalized for any illnesses or operations? If yes, please explain. YES NO NOT SURE/MAYBE
-
15. Do you have or have you ever had any of the following? Please check.
- | | | | | | |
|--|--|---------------------------------------|--|--|---------------------------------------|
| <input type="checkbox"/> chest pain, angina | <input type="checkbox"/> rheumatic fever | <input type="checkbox"/> pacemaker | <input type="checkbox"/> steroid therapy | <input type="checkbox"/> seizures (epilepsy) | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> heart attack | <input type="checkbox"/> mitral valve | <input type="checkbox"/> lung disease | <input type="checkbox"/> diabetes | <input type="checkbox"/> kidney disease | <input type="checkbox"/> medications |
| <input type="checkbox"/> stroke | <input type="checkbox"/> prolapse | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> stomach ulcers | <input type="checkbox"/> thyroid disease | (e.g. Fosamax, |
| <input type="checkbox"/> shortness of breath | <input type="checkbox"/> heart murmur | <input type="checkbox"/> cancer | <input type="checkbox"/> arthritis | <input type="checkbox"/> drug/alcohol dependency | Actonel) |
16. Are there any conditions or diseases not listed above that you have or have had? If so, what? YES NO NOT SURE/MAYBE
-
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
-
18. Do you smoke or chew tobacco products? YES NO NOT SURE/MAYBE
-
19. Are you nervous during dental treatment? YES NO NOT SURE/MAYBE
-
20. **For women only:** Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date? YES NO NOT SURE/MAYBE
-

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

PATIENT/PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

DENTIST SIGNATURE: _____ DATE: _____

DENTIST'S NOTES



PATIENT INFORMATION

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient Name: _____ Date of Birth: _____ Sex: _____ Age: _____
 Home Address: _____ City: _____ State: _____ Zip: _____
 Billing Address (If Different): _____ City: _____ State: _____ Zip: _____
 Home Telephone: _____ Driver's License #: _____ State: _____
 SS #: _____ Employer/Occupation: _____ Bus. Phone: _____
 Spouse's name & phone #: _____ Emergency Phone #: _____
 Primary dental insurance: _____ Group #: _____
 Secondary dental insurance: _____ Group #: _____
 Subscriber' name: _____ Date of birth: _____ SS #: _____
 Name of your medical doctor: _____ Date of last visit to medical doctor: _____
 Name of previous dentist: _____ Date of last visit to dentist: _____
 Referred to us by: _____

DENTAL HEALTH HISTORY

Yes No	Yes No
Are you apprehensive about dental treatment? _____ <input type="checkbox"/> <input type="checkbox"/>	How often do you brush? _____
Have you had problem with previous dental treatment? _____ <input type="checkbox"/> <input type="checkbox"/>	How often do you floss? _____
Do you gag easily? _____ <input type="checkbox"/> <input type="checkbox"/>	Does your jaw make noise so that it bothers you or others? _____ <input type="checkbox"/> <input type="checkbox"/>
Do you wear dentures? _____ <input type="checkbox"/> <input type="checkbox"/>	Do you clench or grind your jaws frequently? _____ <input type="checkbox"/> <input type="checkbox"/>
Does food catch between your teeth? _____ <input type="checkbox"/> <input type="checkbox"/>	Do your jaw ever feel tired? _____ <input type="checkbox"/> <input type="checkbox"/>
Do you have difficulty in chewing your food? _____ <input type="checkbox"/> <input type="checkbox"/>	Does your jaw get stuck so that you can't open freely? _____ <input type="checkbox"/> <input type="checkbox"/>
Do you chew on only one side of your mouth? _____ <input type="checkbox"/> <input type="checkbox"/>	Does it hurt when you chew or open wide to take a bite? _____ <input type="checkbox"/> <input type="checkbox"/>
Do you avoid brushing any part of your mouth because of pain? _____ <input type="checkbox"/> <input type="checkbox"/>	Do you have earaches or pain in front of the ears? _____ <input type="checkbox"/> <input type="checkbox"/>
Do you gums bleed easily? _____ <input type="checkbox"/> <input type="checkbox"/>	Do you have any jaw symptoms or headaches upon awaking in the morning? _____ <input type="checkbox"/> <input type="checkbox"/>
Do your gums bleed when you floss? _____ <input type="checkbox"/> <input type="checkbox"/>	Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities? _____ <input type="checkbox"/> <input type="checkbox"/>
Do your gums feel swollen or tender? _____ <input type="checkbox"/> <input type="checkbox"/>	Do you find jaw pain or discomfort extremely frustrating or depressing? _____ <input type="checkbox"/> <input type="checkbox"/>
Have you ever noticed slow-healing sores in or about your mouth? _____ <input type="checkbox"/> <input type="checkbox"/>	Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)? _____ <input type="checkbox"/> <input type="checkbox"/>
Are your teeth sensitive? _____ <input type="checkbox"/> <input type="checkbox"/>	Do you have temporomandibular (jaw) disorder (TMD)? _____ <input type="checkbox"/> <input type="checkbox"/>
Do you feel twinges of pain when your teeth come in contact with :	Do you have pain in the face, cheeks, jaws, joints, throat, or temples? _____ <input type="checkbox"/> <input type="checkbox"/>
Hot foods or liquids? _____ <input type="checkbox"/> <input type="checkbox"/>	Are you unable to open your mouth as far as you want? _____ <input type="checkbox"/> <input type="checkbox"/>
Cold foods or liquids? _____ <input type="checkbox"/> <input type="checkbox"/>	Are you aware of an uncomfortable bite? _____ <input type="checkbox"/> <input type="checkbox"/>
Sours? _____ <input type="checkbox"/> <input type="checkbox"/>	Have you had a blow to the jaw (trauma)? _____ <input type="checkbox"/> <input type="checkbox"/>
Sweets? _____ <input type="checkbox"/> <input type="checkbox"/>	Are you habitual gum chewer or pipe smoker ? _____ <input type="checkbox"/> <input type="checkbox"/>
Do you take fluoride supplements? _____ <input type="checkbox"/> <input type="checkbox"/>	
Are you dissatisfied with the appearance of your teeth? _____ <input type="checkbox"/> <input type="checkbox"/>	
Do you prefer to save your teeth? _____ <input type="checkbox"/> <input type="checkbox"/>	
Do you want complete dental care? _____ <input type="checkbox"/> <input type="checkbox"/>	