Medical Questionnaire

Name: _____ **Date of Birth:** _____

Your current physical health is: Good Fair Poor

Do you have a personal physician? Yes or No

If under care, please explain why: _____

Physician's Name: _____

Tel: _____ Date of last visit: _____

In the event of an emergency, is there someone who lives near you that we should contact?

Name: _____ Relation: _____

Home tel: _____ Cell tel: _____

Are you taking birth control pills? Yes or No
Are you pregnant? Yes or No If so, week # ? _____
Are you nursing? Yes or No

Are you currently taking blood thinner or aspirin? Y N
Are you currently taking any other medications? Y N

Please list: _____

_____

Reason for medication:_____

_____

Are you allergic to any of the following medications?

Y N Dental Anesthetic
Y N Erythromycin
Y N Latex
Y N Penicillin
Y N Codeine
Y N Other _____

Y N Heart Attack
Y N Heart Surgery/Pacemaker
Y N Heart Murmur
Y N Mitral Valve Prolapse
Y N Congenital Heart Defects
Y N Rheumatic fever
Y N Artificial Valves/Joints
Y N Stints placed
Y N High or Low blood pressure
Y N Hemophilia/Bleeding
Y N Blood Transfusion
Y N Hepatitis - A B C
Y N Anemia
Y N Difficulty breathing
Y N Emphysema
Y N Asthma
Y N Allergies (seasonal)
Y N Sinus Problems
Y N Do you smoke?
Y N Use smokeless tobacco?
Y N Tuberculosis
Y N Cancer
Y N Radiation/Chemo
Y N Stroke
Y N Kidney Defects
Y N Diabetes
Y N Ulcers/Colitis
Y N Severe/Frequent Headaches
Y N Arthritis
Y N Epilepsy/Seizures
Y N Fainting
Y N Thyroid Problems
Y N Drug/Alcohol abuse
Y N Psychiatric Problems
Y N Venereal disease
Y N HIV+
Y N Hospitalized for any reason? _____
Y N Need premedicated?

Any additional medical problems or medical alerts?

_____
_____
_____
_____
_____
_____
_____
_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

Signature: _____ **Date:** _____ **Reviewed by Dr.**_____
(Patient/Responsible party)

Office use only

Signature: _____ **Date:** _____ **Reviewed by Dr.**_____
(Patient/Responsible party)

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, CDC, and the ADA.