

# Medical Questionnaire

Name \_\_\_\_\_

Correct answers to the following questions will allow your dentist to treat you so there WILL NOT be an emergency. However, if an emergency situation does arise this information will help insure proper treatment. As before, your answers are for our records only and will be considered confidential.

## Do you have or have you ever had:

Anemia  Yes  No  Previously  
Asthma  Yes  No  Previously  
Tuberculosis  Yes  No  Previously  
Diabetes  Yes  No  Previously  
HIV/AIDS  Yes  No  Previously  
Hepatitis Type: \_\_\_\_\_  Yes  No  Previously  
Epilepsy  Yes  No  Previously  
Psychiatric Treatment  Yes  No  Previously  
Drug/Alcohol Dependent  Yes  No  Previously  
Recreational Drug Use  Yes  No  Previously  
High Blood Pressure  Yes  No  Previously  
Abnormal Bleeding  Yes  No  Previously  
Pregnant or Nursing  Yes  No  
Joint Replacement  Yes  No

If yes, what & when \_\_\_\_\_

### Allergies

To Penicillin  Yes  No  
To Latex  Yes  No  
To Anesthetic  Yes  No  
Other \_\_\_\_\_

Abnormal Heart Condition  Yes  No  Previously  
Rheumatic Fever  Yes  No  Previously  
Mitral Valve Prolapse  Yes  No  Previously  
Heart Murmur  Yes  No  Previously  
Stroke  Yes  No

If so, when \_\_\_\_\_

Heart Attack  Yes  No

If so, when \_\_\_\_\_

Heart Surgery  Yes  No

If so, when \_\_\_\_\_

Pacemaker  Yes  No

Date Placed \_\_\_\_\_

Cancer  Yes  No  Previously

If yes, what type \_\_\_\_\_

Chemo or Radiation  Yes  No  Previously

If yes, when \_\_\_\_\_

Any Mental Limitations  Yes  No

If yes, in what way \_\_\_\_\_

Any Physical Limitations  Yes  No

If yes, in what way \_\_\_\_\_

Are you taking ANY medication? *This includes prescription, herbal & over the counter medicines?*  Yes  No

If yes, please list \_\_\_\_\_

Please note any disease, condition or problem not listed. \_\_\_\_\_

Are you being monitored by a Doctor for anything right now?  Yes  No

If yes, for what? \_\_\_\_\_

Date of last medical exam \_\_\_\_\_ Name of Physician(s) \_\_\_\_\_

Pharmacy Preference \_\_\_\_\_ Phone # \_\_\_\_\_

In case of emergency, who should be notified? Name \_\_\_\_\_ Phone \_\_\_\_\_

Relationship \_\_\_\_\_

To the best of my knowledge all the preceding answers are true and correct.

I will inform your office of any changes at the next appointment

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date