

Patient Name: _____ Birthdate ____ / ____ / ____ SS# _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone – Home: _____ Cell: _____ Work: _____
 Emergency contact name and phone #: _____
 How did you hear about us? _____

MEDICAL HISTORY QUESTIONNAIRE

1. Please check "Yes" or "No":

- Are you under physician's care now? Yes or No If yes, please explain _____
- Have you ever had a reaction to epinephrine or any dental anesthetic used to get you numb ? Yes or No
If yes, please explain _____
- Have you ever had a serious head or neck injury or head/neck RADIATION ? Yes or No
If yes, please explain _____
- Are you currently taking a blood thinner ? Yes or No
- Please list prescription medications and over the counter medications and purpose, e.g. *blood pressure pill*:

2. Women patients:

- Are you pregnant or trying to get pregnant ? Yes or No Nursing ? Yes or No
- Are you taking oral contraception ? Yes or No

3. Are you allergic to any of the following?: Yes or No

- Aspirin Penicillin Codeine Local Anesthetic Acrylic Metal Latex Sulfa Other _____

4. Do you have or have you had any of the following? (check the box next to the condition):

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Radiation Treatments |
| <input type="checkbox"/> Arthritis / Gout | <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Stomach / Intestinal Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting Spells / Dizziness | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Attack / Failure | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Replaced / Artificial Joint |
| <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Heart Trouble / Disease | <input type="checkbox"/> Pain in Jaw Joints | What? _____ Year? _____
What? _____ Year? _____
What? _____ Year? _____ |

5. Have you ever had any serious illness not listed above? Yes or No

If yes, explain: _____

To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

**SIGNATURE OF PATIENT,
 PARENT OR GUARDIAN** _____

DATE _____