Medical Questionnaire

Correct answers to the following questions will help us provide safe treatment for you.

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
(Cocaine can kill you with dental treatment)
High Blood Pressure ☐ Yes ☐ No ☐ Previously
Abnormal Bleeding ☐ Yes ☐ No ☐ Previously
Pregnant/Nursing Now ☐ Yes ☐ No
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______________________________________

Joint Replacement ☐ Yes ☐ No
If so, when______________________________________
Allergies
To Penicillin ☐ Yes ☐ No
To Latex ☐ Yes ☐ No
To Anesthetic ☐ Yes ☐ No
Other________________________________
Heart Attack / Surgery ☐ Yes ☐ No
If so, when______________________________________
Any Internal Electrical Device ☐ Yes ☐ No
(Pacemaker and Monitor, Insulin Pump, etc.)
If so, when______________________________________
Cancer ☐ Yes ☐ No
If so, when______________________________________
Chemo or Radiation ☐ Yes ☐ No
If so, when______________________________________
Any Physical / Psycological Disabilities ☐ Yes ☐ No
List______________________________________
____
____

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)_______________________Phone #__________________________

Pharmacy Preference____Phone #__________________________________

In case of emergency, who should be notified? Name______________________Phone #__________________________________

Relationship________________________

To the best of my knowledge all the preceeding answers are true and correct.
I will inform your office of any changes at the next appointment

Name____ ______________________________________ ______________
Signature of Patient or Guardian Date

Address ____

Phone #____

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