MEDICAL QUESTIONNAIRE

Patient Name____ **Date Today** ____________

Please check if you have any of the following problems:

- ☐ AIDS / HIV Positive
- ☐ Alcoholism
- ☐ Allergies

Describe ______________

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- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial heart valves
- ☐ Artificial joints
- ☐ Asthma
- ☐ Back problems
- ☐ Blood disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Circulation problems
- ☐ Cortisone treatments
- ☐ Cough, persistent
- ☐ Cough, up blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Food allergies
- ☐ Glaucoma
- ☐ Headaches, frequent
- ☐ Headaches, migraines
- ☐ Heart murmur
- ☐ Heart, any problems

Describe______________

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- ☐ Hemophilia
- ☐ Herpes
- ☐ Hepatitis A B C
- ☐ High blood pressure
- ☐ Jaw pain
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Mitral valve prolapse
- ☐ Nervous problems
- ☐ Pacemaker
- ☐ Psychiatric care
- ☐ Radiation treatment
- ☐ Respiratory disease
- ☐ Rheumatic fever
- ☐ Seizure disorders
- ☐ Shingles
- ☐ Shortness of breath
- ☐ Skin rash
- ☐ Stroke
- ☐ Surgical implants
- ☐ Swelling, feet or ankles
- ☐ Thyroid problems
- ☐ Tobacco use
- ☐ Tuberculosis
- ☐ Ulcers/colitis

Known Allergies:

- ☐ Local anesthetic
- ☐ Aspirin
- ☐ Penicillin
- ☐ Codeine
- ☐ Sulfa
- ☐ Iodine
- ☐ Latex
- ☐ Other:__________________

List any medications you are currently taking:

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Pre-medication required _________

Consulting Physician _______________________________

Pharmacy _____________________________________

Check if you have had any problems with the following:

- ☐ Bad breath
- ☐ Bleeding, sensitive gums
- ☐ Clicking or popping jaw: right or left
- ☐ Food trapped between teeth
- ☐ Grinding or clenching teeth
- ☐ Loose teeth
- ☐ Broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity to biting
- ☐ Sores in mouth
- ☐ Staining

Authorization:

I have reviewed the information and answered all questions to the best of my knowledge. I understand this information will be used to determine the dental treatment I receive at this office and may be shared with other medical offices only as necessary. I will notify the office should any information change in the future.

Signature of patient, or parent if a minor: ______________________________________

Reviewed by: ___________