MEDICAL HISTORY QUESTIONNAIRE

NAME: AGE__

DATE OF BIRTH (DAY/MONTH/YEAR): /

MAILING ADDRESS (HOME):
P.O. Box

CELL PHONE:

HOME PHONE:

EMAIL ADDRESS:

MCP:

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME:

RELATIONSHIP:

DAY-TIME PHONE:

NAME OF FAMILY DOCTOR:

PHONE OR ADDRESS:

Other Insurance:

Only MCP Coverage:

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

1. Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why?
☐ YES ☐ NO ☐ NOT SURE/MAYBE

2. Has there been any change in your general health in the past year? If yes, please explain. ☐ YES ☐ NO ☐ NOT SURE/MAYBE

3. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list. ☐ YES ☐ NO

4. Do you have any allergies or have you had a reaction to any medications/injections? If you answered yes, please list below:
☐YES ☐ NO ☐ NOT SURE/MAYBE

5. Do you have or ever had asthma? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

6. Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

7. Do you have a prosthetic or artificial joint? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

8. Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

9. Have you ever had hepatitis, jaundice or liver disease? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

10. Do you have a bleeding problem or bleeding disorder? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

11. Have you ever been hospitalized for any illnesses or operations? If yes, please explain. ☐ YES ☐ NO ☐ NOT SURE/MAYBE

12. Do you have or have you ever had any of the following? Please check.

☐ chest pain, angina
☐ heart attack
☐ stroke
☐ shortness of breath
☐ rheumatic fever
☐ mitral valve prolapse
☐ heart murmur
☐ pacemaker
☐ lung disease
☐ tuberculosis
☐ cancer
☐ steroid therapy
☐ diabetes
☐ stomach ulcers
☐ arthritis
☐ seizures (epilepsy)
☐ kidney disease
☐ thyroid disease
☐ drug/alcohol dependency
☐ osteoporosis medications (e.g. Fosamax, Actonel)

13. Are there any conditions or diseases not listed above that you have or have had? If so, what?

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14. Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease) ☐ YES ☐ NO ☐ NOT SURE/MAYBE

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15. Do you smoke or chew tobacco products? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

16. Are you nervous during dental treatment? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

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17. **For women only:** Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date?

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18. When was your last dental visit / dental x-rays? ____________________

19. What are your present dental concerns?
    - ☐ Bleeding gums ☐ Toothache ☐ Crooked teeth ☐ Sensitivity ☐ Loose teeth
    - ☐ Missing teeth ☐ Areas of recession ☐ Jaw clicking/pain

20. Are you dissatisfied with the appearance of your teeth or with your smile? ☐ YES ☐ NO

21. Have you considered Invisalign or Implants? ☐ YES ☐ NO

22. Would you be interested in a consultation for Invisalign? ☐ YES ☐ NO

23. Would you be interested in a consultation for Implants? ☐ YES ☐ NO

If you have any questions or concerns that have not been previously mentioned please feel free to speak to your Dentist or Hygienist.

To the best of my knowledge, the above information is correct:

PATIENT/PARENT/GUARDIAN SIGNATURE: **DATE:**

DENTIST SIGNATURE: **DATE:**

DENTIST'S NOTES