MEDICAL HISTORY QUESTIONNAIRE

MEDICAL ALERT: ______________________

Date: ______________________

Patient Name: ____ **DOB:** ______________________

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 . . . both sides.***

Are you being treated for a medical condition at the present time or have you been treated within the past year? If yes, please specify: ______________________ Yes ☐ No ☐

When was your last medical checkup? ______________________

Has there been any change in your general health in the past year? If yes, please explain: Yes ☐ No ☐

____

____

Are you taking any medications, non-prescription drugs or herbal medicines of any kind? If yes, please list: Yes ☐ No ☐

____

____

Do you have any allergies? If yes, please list using the following categories: Yes ☐ No ☐

- Medications: ______________________
- Latex/rubber products: ______________________
- Other (eg. hay fever, foods, metals): ______________________

Have you ever had a peculiar or adverse reaction to any medications or injection? If yes, please explain: Yes ☐ No ☐

____

Have you ever been hospitalised for any illness or operations? If yes, please explain: Yes ☐ No ☐

____

____

Are there any diseases or medical problems that run in your family? (eg. diabetes, cancer, or heart disease) Yes ☐ No ☐

If yes, please list: ______________________

Are there any other problems or concerns of which the dentist should be made aware? Yes ☐ No ☐

Have you been advised by your Medical Doctor or Dentist to take antibiotics prior to dental treatment? Yes ☐ No ☐

Do you smoke or use any other forms of tobacco? Yes ☐ No ☐

Are you alcohol and/or drug dependent? Yes ☐ No ☐

Do you have, or have you ever had, any of the following? Please check the appropriate boxes:

- Organ transplant (eg. kidney, heart, lung, liver) Yes ☐ No ☐
- Pacemaker Yes ☐ No ☐
- Prosthetic or artificial heart valve Yes ☐ No ☐
- Prosthetic or artificial joint (eg. hip, knee) Yes ☐ No ☐

For women only: Are you breastfeeding or pregnant? Yes ☐ No ☐

If pregnant, when is the expected delivery date? ______________________

Are you taking birth control pills? Yes ☐ No ☐

PLEASE CONTINUE ON THE BACK OF THIS PAGE

Please indicate which of the following you presently have or ever had:

Condition	Yes	No	Condition	Yes	No
Alzheimer's/dementia	Yes ☐	No ☐	High blood pressure	Yes ☐	No ☐
AIDS	Yes ☐	No ☐	HIV positive	Yes ☐	No ☐
Anaemia	Yes ☐	No ☐	Hodgkin's lymphoma	Yes ☐	No ☐
Angina pectoris/chest pain	Yes ☐	No ☐	Hyperglycemia	Yes ☐	No ☐
Arthritis-rheumatism	Yes ☐	No ☐	Hypoglycemia	Yes ☐	No ☐
Asthma	Yes ☐	No ☐	Inflammatory bowel disease	Yes ☐	No ☐
Bleeding/blood disorders	Yes ☐	No ☐	Jaundice	Yes ☐	No ☐
Bronchitis	Yes ☐	No ☐	Kidney disease	Yes ☐	No ☐
Cancer	Yes ☐	No ☐	Leukemia	Yes ☐	No ☐
Chemotherapy	Yes ☐	No ☐	Liver disease	Yes ☐	No ☐
Circulation problems	Yes ☐	No ☐	Low blood pressure	Yes ☐	No ☐
Congenital heart defects	Yes ☐	No ☐	Lupus	Yes ☐	No ☐
Cortisone/steroid therapy	Yes ☐	No ☐	Malignant hyperthermia	Yes ☐	No ☐
Dental phobia	Yes ☐	No ☐	Manic depressive	Yes ☐	No ☐
Depression	Yes ☐	No ☐	Mental/nervous disorders	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	Mitral valve prolapse	Yes ☐	No ☐
Eating disorders (eg. anorexia, bulimia)	Yes ☐	No ☐	Post-Traumatic Stress Disorder	Yes ☐	No ☐
Emphysema	Yes ☐	No ☐	Psychiatric treatment	Yes ☐	No ☐
Epilepsy or seizures	Yes ☐	No ☐	Radiation treatment	Yes ☐	No ☐
Fainting or dizzy spells	Yes ☐	No ☐	Rheumatic fever	Yes ☐	No ☐
Glandular disorders	Yes ☐	No ☐	Schizophrenia	Yes ☐	No ☐
Head/neck injuries	Yes ☐	No ☐	Shortness of breath	Yes ☐	No ☐
Heart disease/heart attack	Yes ☐	No ☐	Sinus trouble	Yes ☐	No ☐
Heart murmur	Yes ☐	No ☐	Stomach/intestinal problems	Yes ☐	No ☐
Heart surgery	Yes ☐	No ☐	Stroke	Yes ☐	No ☐
Hepatitis A	Yes ☐	No ☐	Thyroid (hyper/hypo)	Yes ☐	No ☐
Hepatitis B	Yes ☐	No ☐	Tuberculosis	Yes ☐	No ☐
Hepatitis C	Yes ☐	No ☐	Ulcers	Yes ☐	No ☐
Herpes	Yes ☐	No ☐	Venereal disease	Yes ☐	No ☐

Are there any diseases or conditions not listed that you have or ever had? ________________ Yes ☐ No ☐

The following questions are intended to help us to identify and/or prevent the transmission of communicable diseases in the community, in institutions, and in professional settings, such as our dental office:

Question	Yes	No
Do you have a cough or shortness of breath?	Yes ☐	No ☐
Have you developed a fever or chills in the last 24 hours?	Yes ☐	No ☐
Have you had a recent and sudden onset of diarrhea?	Yes ☐	No ☐
Have you had an undiagnosed rash, lesion, or break in the skin?	Yes ☐	No ☐
Have you had a recent exposure to communicable infectious disease, (eg. measles, chicken pox, whooping cough, scarlet fever, sexually transmitted diseases, tuberculosis, etc.)?	Yes ☐	No ☐
Have you recently received antimicrobial therapy, (eg. antibiotics, antifungals, antivirals, etc.)?	Yes ☐	No ☐
If so, for what reason? ________________		
Do you have a family history of prion disease (mad cow disease) or symptoms that may be indicative of Creutzfeldt-Jakob disease (CJD), such as the onset of dementia?	Yes ☐	No ☐
Have you recently travelled to areas where endemic diseases are present?	Yes ☐	No ☐
Are your immunisations up to date?	Yes ☐	No ☐
Are you taking any medications for immunosuppression?	Yes ☐	No ☐

To the best of my knowledge, the above information is accurate. ________________ **Date:** ________________

PATIENT/PARENT/GUARDIAN SIGNATURE

Medical information is held in strict confidence. Reviewed by: Dr. ________________ **Date:** ________________