Medical Questionnaire

Correct answers to the following questions will allow your dentist to treat you so there **WILL NOT** be an emergency. However,if an emergency situation does arise this information will help insure proper treatment. As before, your answers are for our records only and will be considered confidential.

MEDICAL HISTORY

Medical doctor's name _____

Are you under a doctor's care now? Why? _____ YES NO

Have you been hospitalized during the past two years? Why? _____ YES NO

Are you taking any medications, pills or drugs? What? _____ YES NO

Are you allergic to any medications or substance? What? _____ YES NO

Are you pregnant? (women) _____ YES NO

Please Circle if you have had any of the following:

Heart Trouble	Chest Pain	Scarlet Fever	Cancer	Hypoglycemia
High Blood Pressure	Shortness of Breath	Asthma	Thyroid Diseases	Psychiatric Care
Low Blood Pressure	Swelling of Feet/Ankles/Hands	Hay Fever	Parathyroid Disease	Drug Addiction
Heart Murmur	Fainting or Dizziness	Sinus Trouble	X-ray or Cobalt Tmt.	Blood Transfusion
Rheumatic Fever	Stroke	Emphysema	Chemotherapy/Radiation	Hemophilia
Congenital Heart Lesion	Diabetes	Frequent Cough	Arthritis/Gout	AIDS
Artificial Heart Valve	Excessive Thirst	Lung Disease	Rheumatism	Venereal Disease
Heart Pacemaker	Artificial Joints/Hips	Tuberculosis	Pain in Jaw Joints	Cold Sores
Heart Surgery	Kidney Trouble	Liver Disease	Cortisone Medicine	Fever Blisters
Blood Disease	Ulcers	Hepatitis A (infec.)	Glaucoma	Herpes
Anemia	Allergies	Hepatitis B (serum)	Epilepsy or Seizures	Bruise Easily
		Yellow Jaundice	Nervousness	Sickle Cell Anemia
		HIV Positive		

Have you ever had any other serious illness not listed above? _____ ☐ YES ☐ NO

Please describe in detail _____

Do you wish to talk to the doctor privately about any other concern _____ ☐ YES ☐ NO

X _____ Date _____

PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed by: Doctor _____ Date _____ B.P. _____

MEDICAL UPDATES

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	B.P.	REVIEWED BY
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____