

Medical Health History Questionnaire

Name: _____ Age: _____ Date: _____
Date of Birth: _____ Sex: M/F Height: _____ Weight: _____
Dentist: _____ Physician: _____

For the following questions, circle yes or no, whichever applies? Your answers are confidential and are for our records only.

Are you in good health? Yes No

Have you been hospitalized in the past 5 Years? Yes No

Are you under the care of a Physician? Yes No

Have you ever:

Had a serious illness. Yes No

Had surgery or an operation in the past. Yes No

Had excessive bleeding after surgery. Yes No

Had a blood transfusion. Yes No

Had any periods of fainting or Unconsciousness. Yes No

Taken any blood thinners (Aspirin, Coumadin, Etc.) Yes No

Had any problems with your Immune system. Yes No

Been treated for alcohol or a drug usage problem. Yes No

Taken any medicine for Osteoporosis. Yes No

If yes, circle all that apply. Fosamax, Reclast, Actonel, Boniva, Aredia, Zometa, or Prolia.

List all Medication:

List all Allergies: NKDA

Do you currently smoke or chew tobacco. Yes No

Did you smoke or chew tobacco in the past. Yes No

Do you have any of the following:

Heart disease, angina, or chest pain. Yes No

Anxiety or Depression. Yes No

Congenital heart defect. Yes No

Heart Murmur.	Yes No
Rheumatic Fever.	Yes No
Stroke or TIA.	Yes No
High blood pressure.	Yes No
Kidney disease, or Dialysis.	Yes No
Lung disease, emphysema, COPD, Tuberculosis, Chronic cough.	Yes No
Asthma.	Yes No
Sinus or nasal problems.	Yes No
Hay fever.	Yes No
Hepatitis or liver disease.	Yes No
Stomach ulcers, Gastritis, Acid reflux, or Crohn's disease.	Yes No
Diabetes.	Yes No
TMJ Problems (pain or popping of Jaw or difficulty opening).	Yes No
Bleeding disorder (von Willebrand's Disease).	Yes No
Recurrent mouth ulcers.	Yes No
Anemia or Sickle Cell Disease.	Yes No
Epilepsy or Seizure Disorder.	Yes No
Thyroid Disease.	Yes No
Cancer.	Yes No
Glaucoma.	Yes No
Arthritis or Osteoporosis.	Yes No
Artificial joints or other implantable devices.	Yes No
Do you have other Dental and/or Medical Problems not listed?	Yes No

Female patients ONLY:

Are you taking Birth Control Pills?	Yes No
Are you breast feeding?	Yes No
Are you currently or is there a possibility that you are pregnant?	Yes No

Patient's Signature: _____

Doctor's Signature: _____