Patient's Name ____ Patient No.____________

Physician's Name ___________________________________ Tel. No.____________

Medical Questionnaire

In order to provide safe dental care for our patient's we are asking you to fill out the following questionnaire. Please answer the questions as accurately as you can. If you have any questions or doubts, check the "not sure / maybe" choice. Your responses will be reviewed with you by the dentist and you can be assured that the information that you provide will be kept in the strictest confidence.

		YES	NOT SURE/ MAYBE	NO
1.	Are you being treated for any medical condition at the present or have you been treated within the last year?	______	______	______
2.	When was your last medical check-up? ______________________________	______	______	______
3.	When was your last visit to a physician? ______________________________	______	______	______
4.	Please give reason. ______________________________	______	______	______
5.	Has there been any change in your general health in the past year?	______	______	______
6.	Are you taking any medications or non-prescription drugs of any kind? If the answer is "yes", please list them below. ______________________________	______	______	______
7.	Do you have any allergies?	______	______	______
8.	Have you ever had a peculiar or adverse reaction to any medicines or injections?	______	______	______
	(e.g. penicillin, aspirin or local anaesthetics, "dental freezing")	______	______	______
9.	Do you have any heart or blood pressure problems?	______	______	______
10.	Do you have heart murmur or mitral valve prolapse?	______	______	______
11.	Have you ever had rheumatic fever?	______	______	______
12.	Do you have or have you ever had jaundice, hepatitis or liver disease?	______	______	______
13.	Have you ever been told that you should not give blood?	______	______	______
14.	Do you have any conditions that could affect your immune system (AIDS, HIV positive, leukemia, etc)?	______	______	______
15.	Do you have a tendency to bruise easily or bleed for a prolonged period of time after being cut?	______	______	______
16.	Have you ever been hospitalized for any serious illness or operations?	______	______	______

17. Do you have or have you ever had any of the following? Please tick off only those that apply.

____ chest pain	____ bronchitis	____ tuberculosis	____ arthritis
____ heart attack	____ emphysema	____ epilepsy	____ diabetes
____ stroke	____ asthma	____ stomach ulcers	____ kidney disease
____ prosthetic joint		____ drug/alcohol dependency	

		YES	NOT SURE/ MAYBE	NO
18.	Are there any conditions or diseases not listed above that you have or have had?	______	______	______

19. If you answered "yes", please list them. ______________________________

____

20. Do you smoke or chew tobacco? Yes ______ No _______

21. For women only, are you pregnant? Yes ______ No _______

22. If so, what is the expected delivery date? ______________________________

Follow-up information to above questions: ______________________________

____

____

____

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

______________________________ ______________
(patient's signature) date

Reviewing by Treating Dentist: ______________________________ ______________
date

Changes to Medical/Dental History

Date	Change	Patient's Initials