DENTAL/MEDICAL QUESTIONNAIRE

MEDICAL HISTORY

FULL NAME_____BIRTHDATE_____AGE_____
SEX____M____F MARITAL STATUS____S____M____W SPOUSE'S NAME_____
ADDRESS_____CITY_____ZIP_____
HOME PHONE NUMBER_____WORK PHONE NUMBER_____
OCCUPATION_____EMPLOYED BY_____
YOUR SOCIAL SECURITY NUMBER _____DRIVERS LICENSE_____
E-MAIL ADDRESS_____
EMERGENCY CONTACT PERSON_____RELATIONSHIP_____
PHONE NUMBER_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? _____YES_____NO IF YES, WHAT_____
_____

DO YOU HAVE ANY CURRENT HEALTH PROBLEMS____YES____NO IF YES,
WHAT_____
ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN? _____YES_____NO
IF YES, FOR WHAT CONDITION? _____

PHYSICIAN'S NAME_____NUMBER_____
ADDRESS_____
HAVE YOU HAD ANY SERIOUS ILLNESS' OR OPERATIONS? ____YES____NO
IF YES, PLEASE EXPLAIN:_____

LIST ALL CURRENT MEDICATIONS YOU ARE TAKING_____
_____

ARE YOU ALLERGIC TO, OR HAVE YOU BECOME SICK FROM, OR BEEN TOLD NOT TO TAKE OR COME IN CONTACT WITH:

____PENICILLIN/AMOXICILLIN ____TETRACYCLINE ____CODEINE/NARCOTICS
____ANESTHESIA (INCL. DENTAL) ____NITROUS OXIDE ____LATEX RUBBER
____OTHERS:_____

PLEASE CHECK ANY OF THE FOLLOWING THAT *YOU HAVE HAD OR CURRENTLY HAVE:*

__AIDS/HIV
__ALLERGIES/HIVES
__ANEMIA
__HAY FEVER
__HEAD INJURY
__HEART MURMUR
__BLOOD THINNER
__EMPHYSEMA
__CANCER
__STROKE
__COLD SORES
__DRUG ADDICTION
__HERPES
__DIABETES__I__II
__HERPES

__EPILEPSY
__EXCESSIVE BLEEDING
__FAINTING SPELLS
__ASTHMA
__HEART ATTACK WHEN____
__RHEUMATIC FEVER
__HEART SURGERY WHEN_____
__SINUS PROBLEMS
__LIVER DISEASE
__CARDIAC PACEMAKER
__KIDNEY DISEASE
__TUBERCULOSIS
__EYE PROBLEMS
__TUMORS/GROWTHS
__THYROID PROBLEMS

__PSHYCHOLOGICAL PROB.
__PSYCHIATRIC TX
__MITRAL VALVE PROLAPSE
__ARTHRITIS
__HEART DISEASE
__ARTIFICIAL IMPLANTS
__PERSIST OR BLOODY COUGH
__ANXIETY/PANIC ATTACK
__ARTIFICIAL HEART VALVE
__RADIATION/CHEMO THERAPY
__HIGH BLOOD PRESSURE
__HEPATITIS__A__B__C
__EAR PROBLEMS
__VENERIAL DISEASES
__SHORTNESS OF BREATH

DENTAL HISTORY

WHAT IS THE PURPOSE OF THIS VISIT? _____

_____

HOW LONG SINCE YOUR LAST DENTAL VISIT? _____

LAST FULL MOUTH X-RAYS? _____

LAST DENTAL TREATMENT? _____

NAME OF FORMER DENTIST? _____

ARE YOU CURRENTLY HAVING PAIN? ____YES____NO

DOES IT HURT WITH: ___HOT___COLD___SWEETS___WHEN BITING DOWN

DO YOU GRIND YOUR TEETH? ____YES____NO

HAVE YOU HAD AN UNFAVORABLE EXPERIENCE FROM LOCAL ANESTHETICS?
_____YES_____NO

IS THERE ANY OTHER MEDICAL OR DENTAL INFORMATION THAT YOU FEEL WE SHOULD KNOW ABOUT? ____YES____NO
IF YES PLEASE EXPLAIN:

_____

_____

FOR WOMEN ONLY
ARE YOU TAKING BIRTH CONTROL PILLS? ____YES____NO
ARE YOU PREGNANT? ____YES____NO
IF YES, HOW MANY MONTHS? _____
NAME OF YOUR OB/GYN? _____PHONE NUMBER_____

I CONFIRM AS TRUE THE ABOVE HEALTH INFORMATION. I WILL NOT HOLD MY DENTIST OR ANY MEMBER OF HIS STAFF RESPONSIBLE FOR ANY ERROR OR OMISSION THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM.
IN ADDITION, I HEREBY AUTHORIZE THE DENTIST TO TAKE X-RAYS, STUDY ,MODELS, PHOTOGRAPH, OR ANY TESTS DEEMED APPROPRIATE BY THE DENTIST IN CHARGE OF MY CARE TO MAKE A THOROUGH DIAGNOSIS OF MY (OR THE PATIENT'S) DENTAL NEEDS. I ALSO AUTHORIZE THE DENTIST TO PERFORM ANY AND ALL FORMS OF TREATMENT, MEDICATION AND THERAPY THAT MAY BE INDICATED.

_____ _____

SIGNATURE ***DATE***

*****ALL INFORMATION GIVEN WILL BE KEPT CONFIDENTIAL AND <u>WILL NOT</u> BE RELEASED TO ANYONE OR ANY AGENCY WITHOUT YOUR WRITTEN PERMISSION******