

MEDICAL QUESTIONNAIRE - Patient name: _____

1. Are you having pain or discomfort at this time? Yes No
2. Do you feel nervous about having dental treatment? Yes No
3. Have you ever had a bad experience in a dental office? Yes No
4. Have you been hospitalized in the past two years? Yes No
5. Have you been under the care of a medical doctor during the past two years? Yes No
6. What are some questions about dentistry and oral health that you have never had adequately answered for you?

Physician's Name _____ Address _____

Physician's Phone _____

7. Have you taken any medications or drugs during the past two years? Yes No List _____
8. Are you now taking any medications, drugs, or pills? Yes No List _____
9. Are you now taking any vitamins, supplements, or herbal therapy? Yes No List _____
10. Are you aware of being allergic to any of the following?
__Aspirin __Erythromycin __Novacaine/Xylocaine __Scopolamine __Darvon __Local Anesthetic
__Other Antibiotics __Nembutal/Seconal __Penicillin __Tetracycline __Codeine __Nitrous Oxide
11. Are you aware of being allergic to any other medication or substance? Yes No If yes, list _____

12. Check any of the following which you have had, or have at present:

- | | | | | | |
|--|--|--|--|--|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Cough | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Allergies/Hives | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Anemia | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Angina Pectoris | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Fainting / Dizzy Spells | <input type="checkbox"/> Seizures | <input type="checkbox"/> Sinus / Hay Fever |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Syphilis | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Heart Lesions |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Cosmetic Surgery | <input type="checkbox"/> Venereal Diseases | <input type="checkbox"/> Psychiatric Trxt |
| <input type="checkbox"/> Yellow Jaundice | <input type="checkbox"/> X-ray/Cobalt Trxt | | | | |

13. Do you ever have shortness of breath or chest pains? Yes No
14. Do you have any prosthetic joints, heart valves, etc.? Yes No
15. Have you lost or gained more than ten pounds in the last year? Yes No
16. Do you ever wake up from sleeping with shortness of breath? Yes No
17. Have you taken Phen-Phen or Redux? Yes No
18. Has your medical doctor ever said you have a cancer or tumor? Yes No
19. Do you have any disease, condition, or problem not listed? Yes No List _____
20. **Women only** Are you pregnant or think you may be? Yes No
21. **Women only** Are you taking birth control pills? Yes No
22. Which of the following have you been given? CPAP Orthodontic Retainer Mouth splint/Night Guard
23. If so, how often do you wear these? _____ Oral Device for Sleep Apnea/Snoring

Consent: *The undersigned hereby authorizes the doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with (name of patient) _____ and further authorize consent that the doctor choose and employ such assistance as s/he deems fit. I also understand that responsibility for payment for dental services provided in this office for my dependents or myself is mine, due and payable at the time services are rendered. In the event of default, I(we) promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees, as may be required, to effect collection of this note.*