



DENTAL/MEDICAL HISTORY QUESTIONNAIRE

MR. MISS MRS. MS. DR.

NAME: _____

DATE OF BIRTH (DAY/MTH/YR): _____ / _____ / _____

ADDRESS (HOME): _____

PHONE NUMBER:

Home: _____

Business: _____

Cell: _____

Email: _____

OCCUPATION: _____

Who referred you to our office:

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

Name: _____

Daytime Phone: _____

Medical Alert _____
MCP Number _____

Dental Insurance Information, if applicable
Primary Insurance
Name of Policy Holder: _____
Date of Birth of above person: _____
Employer: _____
Insurance Company: _____
Insurance Policy No: _____
Certificate I.D.: _____

Family Doctor: _____

Address or Telephone: _____

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private. We will review the questions and explain any you do not understand. Please fill in the entire form.

- When was your last dental visit? _____
- When did you last have dental x-rays? _____
- How often are your teeth cleaned in a dental office (e.g. every 3 months)? _____
- How often do you brush your teeth? _____
- Do you use: a. Manual or electric brush (check one) b. Soft med. hard bristles (check one)
- How often do you floss your teeth? _____
- List any other oral hygiene measures you use: (e.g. rinses, waterpik) _____
- Have you ever been advised to take antibiotics prior to dental work? Yes No Not Sure/Maybe
- Do your gums bleed when you brush your teeth? Yes No Not Sure/Maybe
- Do you have any pain when you chew? Yes No Not Sure/Maybe
- Have you ever had orthodontic treatment? Yes No Not Sure/Maybe
- Have you ever had dental implant treatment? Yes No Not Sure/Maybe
 - If Yes: Dentist who performed surgery and when: _____
- Do you wear partial or complete dentures? Yes No Not Sure/Maybe
- Please list anything else not mentioned above regarding your dental history: _____

Medical History

1. List any medical condition you are being treated for or have been treated for in the past year:

2. When was your last medical checkup? _____

3. Has there been any change in your general health in the past year? Yes No Not Sure/Maybe

If Yes, please explain: _____

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind?

Yes No Not Sure/Maybe

If Yes, please list: _____

5. Do you have any allergies?

Yes No Not Sure/Maybe

If Yes, please list: _____

6. Have you ever had an adverse reaction to medicines or injections? Yes No Not Sure/Maybe

If Yes, please explain: _____

7. Do you have or have ever had asthma?

Yes No Not Sure/Maybe

8. Do you or have you ever had heart or blood pressure problems?

Yes No Not Sure/Maybe

9. Do you have or have ever had a heart murmur, mitral valve prolapse or rheumatic fever?

Yes No Not Sure/Maybe

10. Do you have a prosthetic or artificial joint?

Yes No Not Sure/Maybe

11. Do you have or have ever had any conditions or therapies that effect your immune system?

(e.g. leukemia, AIDS, HIV infection, chemotherapy) Yes No Not Sure/Maybe

12. Do you have or have ever had hepatitis, jaundice or liver disease?

Yes No Not Sure/Maybe

13. Do you have a bleeding problem or disorder?

Yes No Not Sure/Maybe

14. Have you ever been hospitalized for an illness or operation?

Yes No Not Sure/Maybe

If Yes, please explain: _____

15. Do you have or have ever had any of the following? Please check

- | | | | | | |
|---------------------------------------|---------------------------------------|--|--|---|---|
| <input type="checkbox"/> chest pain | <input type="checkbox"/> pacemaker | <input type="checkbox"/> thyroid disease | <input type="checkbox"/> steroid therapy | <input type="checkbox"/> seizures | <input type="checkbox"/> drug/alcohol addiction |
| <input type="checkbox"/> heart attack | <input type="checkbox"/> osteoporosis | <input type="checkbox"/> lung disease | <input type="checkbox"/> diabetes | <input type="checkbox"/> kidney disease | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> stroke | <input type="checkbox"/> arthritis | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> stomach ulcers | <input type="checkbox"/> cancer | <input type="checkbox"/> prosthetic heart valve |

16. Do you have or have ever had any conditions not listed above?

Yes No Not Sure/Maybe

If Yes, please list: _____

17. Are there any medical conditions that run in your family?

(e.g. diabetes, cancer, heart disease)

Yes No Not Sure/Maybe

18. Do you smoke or chew tobacco product?

Yes No Not Sure/Maybe

If Yes, how much? _____

19. Are you nervous during dental treatment?

Yes No Not Sure/Maybe

20. For women only: Are you breast-feeding or pregnant?

Yes No Not Sure/Maybe

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

Patient/Parent/Guardian Signature

Date (MM/DD/YYYY)

Dentist Signature

Date (MM/DD/YYYY)