MEDICAL HISTORY QUESTIONNAIRE

DIRECTIONS

IF YOUR ANSWER IS YES TO THE QUESTION, PUT A CIRCLE AROUND "YES"
IF YOUR ANSWER IS NO TO THE QUESTION, PUT A CIRCLE AROUND "NO"
ANSWER ALL QUESTIONS AND FILL IN BLANK SPACES WHERE INDICATED

ANSWERS TO THESE QUESTIONS ARE FOR OUR RECORDS ONLY AND ARE CONSIDERED CONFIDENTIAL

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Are you in good health YES NO

Has there been any change in your general health within the past year YES NO

Date of last physical examination_____
Are you currently under the care of a physician? YES NO

If yes, for what condition are you being treated?

_____

_____

The name and address of your physician is:

_____

_____

_____

Have you ever had any serious illness or operation? YES NO
What was the problem?_____
_____

Have you had or do you have any of the following diseases or conditions?

Rheumatic fever YES NO
Congenital heart lesions YES NO
Cardiovascular disease, heart attack, coronary insufficiency angina pain, high blood pressure, stroke YES NO
Pacemaker YES NO
Do you get pain in your chest on exertion YES NO
Do your ankles swell YES NO
Allergies or Hives YES NO
Diabetes YES NO
HIV YES NO
AIDS YES NO
Hepatitis, jaundice or liver disease YES NO

Kidney trouble YES NO
Tuberculosis YES NO
Persistent cough YES NO
Nervousness YES NO
Epilepsy or seizures YES NO
Radiation or chemotherapy YES NO
Arthritis YES NO
Stomach ulcers YES NO

Are you **taking** any drug or medicine? If so, what? YES NO

_____

Are you taking Aspirin, Vitamin E or Ginkgo Biloba? YES NO

Are you **allergic** to any medication or have you reacted adversely to any medication? If so, what was it?_____

_____

Have you ever reacted adversely to:
Local anesthetics (novocaine) YES NO
Penicillin or other antibiotics YES NO
Barbiturates, sedatives or sleeping pills YES NO
Aspirin YES NO
Sulfites YES NO

Have you had any serious trouble associated with previous dental treatment? YES NO

If so, explain_____
_____

WOMEN

Are you pregnant? YES NO

Do you have problems associated with your menstrual cycle? YES NO

Signature of Patient_____

Signature of Dentist_____