HIGH COUNTRY DENTAL ANNUAL UPDATE
MEDICAL QUESTIONNAIRE

Patient Name:____**DateToday**:_______________

Email:____ **Phone #:**____________________________**Home or Cell**

Please check √ if you have or have had any of the following conditions:

__ AIDS/HIV Positive
__ Alcoholism
__ Allergies: _________
Describe__________
__ Asthma
__ Anemia
__ Arthritis
__ Artificial heart valves
__ Artificial joints: ________
____
__ Back problems
__ Blood disease
__ Cancer______________
__ Chemotherapy
__ Circulation problems
__ Cortisone treatment
__ Cough, persistent
__ Cough, with blood
__ C-PAP Machine
__ Cholesterol

__ Diabetes
__ Epilepsy
__ Fainting
__ Food Allergies
__ Glaucoma
__ Headaches, frequent
__ Headaches, migraines
__ Heart murmur
__ Heart, any problems
describe: ___________
____
__ Hemophilia
__ Herpes
__ Hepatitis A B C
__ High blood pressure
__ Jaw pain
__ Kidney disease
__ Liver Disease
__ Osteoporosis
__Pregnancy

__ Mitral valve prolapse
__ Nervous problems
__ Pacemaker
__ Psychiatric Care
__ Radiation treatment
__ Respiratory disease
__ Rheumatic fever
__ Seizure disorders
__ Shingles
__ Shortness of breath
__ Skin rash
__ Stroke
__ Surgical implants
__ Swelling, feet or ankles
__ Thyroid problems
__ Tobacco use: (circle one)
Chew/Smoke/Vaping
__ Ulcers/colitis
__ Facial Trauma

Known Allergies:
__ Local Anesthetic
__ Aspirin
__ Penicillin
__ Codeine
__ Sulfa
__ Iodine
__ Latex
__ Other: ___________________

List any medications you are currently taking:
____
____
____
____

Pre-medication required_________
Consulting Physician____
Pharmacy____

Check if you have had any problems with the following:

__ Bad Breath
__ Bleeding, sensitive gums
__ Clicking or popping jaw: right or left
__ Food trapped between teeth
__ Grinding or clenching teeth
__ Loose teeth
__ Broken fillings

__ Periodontal treatment
__ Sensitivity to cold
__ Sensitivity to hot
__ Sensitivity to sweets
__ Sensitivity to biting
__ Sores in mouth
__ Staining

Authorization:
I have reviewed the information and answered all questions to the best of my knowledge. I understand this information will be used to determine the dental treatment I receive at this office and may be shared with other medical offices only as necessary. I will notify the office should any information change in the future.

Signature of patient, or parent if a minor:____
Reviewed by: ____________