Medical Health History Questionnaire

Name: ___________________________________ **Age:** __________ **Date:** __________________

Date of Birth: _____________ **Sex: M/F** **Height:** ___________ **Weight:** __________________

Dentist: ____________________________________ **Physician:** _______________________________

Pharmacy ______________________________ Address ____________________________________

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For the following questions, circle yes or no, whichever applies? Your answers are confidential and are for our records only.

Are you in good health? Yes No

Have you been hospitalized in the past 5 Years? Yes No

Are you under the care of a Physician? Yes No

Have you ever:

Had a serious illness. Yes No

Had surgery or an operation in the past. Yes No

Had excessive bleeding after surgery. Yes No

Had a blood transfusion. Yes No

Had any periods of fainting or Unconsciousness. Yes No

Taken any blood thinners (Aspirin, Coumadin, Etc.) Yes No

Had any problems with your Immune system. Yes No

Been treated for alcohol or a drug usage problem. Yes No

Taken any medicine for Osteoporosis. Yes No

If yes, circle all that apply. Fosamax, Reclast, Actonel, Boniva, Aredia, Zometa, or Prolia.

List all Medication:

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____

List all Allergies: **NKDA**

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Do you currently smoke or chew tobacco. Yes No

Did you smoke or chew tobacco in the past. Yes No

Do you have any of the following:

Heart disease, angina, or chest pain. Yes No

Anxiety or Depression. Yes No

Congenital heart defect. Yes No

Heart Murmur. Yes No

Rheumatic Fever. Yes No

Stroke or TIA. Yes No

High blood pressure. Yes No

Kidney disease, or Dialysis. Yes No

Lung disease, emphysema, COPD, Tuberculosis, Chronic cough. Yes No

Asthma. Yes No

Sinus or nasal problems. Yes No

Hay fever. Yes No

Hepatitis or liver disease. Yes No

Stomach ulcers, Gastritis, Acid reflux, or Crohn's disease. Yes No

Diabetes. Yes No

TMJ Problems (pain or popping of Jaw or difficulty opening). Yes No

Bleeding disorder (von Willebrand's Disease). Yes No

Recurrent mouth ulcers. Yes No

Anemia or Sickle Cell Disease. Yes No

Epilepsy or Seizure Disorder. Yes No

Thyroid Disease. Yes No

Cancer. Yes No

Glaucoma. Yes No

Arthritis or Osteoporosis. Yes No

Artificial joints or other implantable devices. Yes No

Do you have other Dental and/or Medical Problems not listed? Yes No

Female patients ONLY:

Are you taking Birth Control Pills? Yes No

Are you breast feeding? Yes No

Are you currently or is there a possibility that you are pregnant? Yes No

Patient's Signature: ____________________________ **Doctor's Signature:** ___________________________________