PATIENT CONFIDENTIAL MEDICAL HISTORY QUESTIONNAIRE

NAME:_____ **DATE OF BIRTH:**_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving.

_____

Physicians Name, Address & Phone Number ***Date of your last physical***

******Is Premedication/Antibiotics required by your physician prior to dental visits? YES OR NO***

If yes, what antibiotics and dosage? _____

Do you have or have you ever had the following:

	YES	NO		YES	NO		YES	NO
Heart Valve Problems			Joint Replacement - **When?**			Tuberculosis		
Rheumatic Heart disease or Rheumatic Fever			Organ Transplant - **When?**			Epilepsy		
Congestive Heart Failure			History of Cancer **Type**:			Stomach Ulcer		
Heart Attack - **When?**			Leukemia			AIDS or HIV Infection		
Artificial Valves - **When?**			History of Chemotherapy or Radiation			Sexually Transmitted Diseases		
Heart Surgery - **When?**			Undergoing Cancer Treatment			Anemia or Blood Disorder		
Heart Trouble or Angina			Sjogren's Syndrome			Have you had any abnormal bleeding		
Heart Murmur			Oral Cancer			Are you taking depression or bipolar medication		
Pacemaker			HPV/Human Papillomavirus			Are you taking aspirin		
Stroke - **When?**			Lung or breathing problems			Are you taking blood thinners ie Coumadin or Plavix		
High Blood Pressure			Asthma			Do you use tobacco/vape products		
Low Blood Pressure			Sinus Trouble			Do you consume alcohol		
Prediabetes			Arthritis or rheumatism			Do you use cocaine or other drugs		
Diabetes			Osteoporosis			***Women only:***		
Chronic Kidney Disease			Thyroid problems			Are you pregnant or think you may be		
Renal Dialysis			Seizures			Are you nursing		
Hepatitis, Jaundice or Liver Disease			Glaucoma			Are you taking birth control pills		

Are you allergic to or have you had reactions to:

	YES	NO		YES	NO
Local Anesthetics like novocaine or epinephrine			Aspirin		
Penicillin			Sulfites		
Erythromycin			Sulfa drugs		
Other known allergies: List:					

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Are you currently under the care of a physician? Explain: _____

_____

Has there been any changes in your general health within the past year? Explain:

_____

_____

Have you been hospitalized for any surgical operation or serious illness, especially within the last 6 months?

Explain: _____

_____

Any other medical problems? Explain: _____

_____

_____

Are you taking any prescription medicine (s): Please list: _____

_____

_____

Are you taking any non-prescription medicine (s): Please list: _____

_____

_____

I certify that the information listed is complete and accurate.

_____

Signature of Patient or Parent of Minor ***Print patient name*** ***Date Required*** ***Email***

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