MEDICAL HISTORY QUESTIONNAIRE

NAME:
Mr./Miss/Mrs./Ms./Dr.

DOB (D/M/Y): / /

ADDRESS:

Postal Code:

CELL #:

HOME PHONE#:

WORK PHONE#:

EMAIL:

EMPLOYER:

OCCUPATION:

WHO REFERRED YOU TO OUR OFFICE?

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME:

RELATIONSHIP:

PHONE#:

NAME OF FAMILY DOCTOR:

PHONE OR ADDRESS:

NAME OF MEDICAL SPECIALIST:

AREA OF SPECIALITY:

PHONE#

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

1. Are you being treated for any medical condition at the present or have you been treated within the past year? If yes, why?
❏ YES ❏ NO

2. When was your last medical checkup?

3. Has there been any change in your general health in the past year? If yes, please explain.
❏ YES ❏ NO

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list.
❏ YES ❏ NO

5. Do you have any allergies? If you answered yes, please list using the categories below:
❏ YES ❏ NO ❏ NOT SURE/MAYBE
a) medications
b) latex/rubber products
c) other (e.g. hayfever, foods)

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.
❏ YES ❏ NO

7. Do you have or have you ever had asthma?
❏ YES ❏ NO

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

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FAMILY & COSMETIC DENTISTRY

9. Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant?
❑ YES ❑ NO

10. Do you have a prosthetic or artificial joint?
❑ YES ❑ NO

11. Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy?
❑ YES ❑ NO

12. Have you ever had hepatitis, jaundice or liver disease?
❑ YES ❑ NO

13. Do you have a bleeding problem or bleeding disorder?
❑ YES ❑ NO

14. Have you ever been hospitalized for any illnesses or operations? If yes, please explain.
❑ YES ❑ NO

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

❑chest pain, angina	❑ rheumatic fever	❑ pacemaker	❑ steroid therapy	❑ seizures (epilepsy)	❑ osteoporosis medications (e.g. Fosamax, Actonel)
❑heart attack	❑ mitral valve prolapse	❑ lung disease	❑ diabetes	❑ kidney disease	
❑stroke	❑ heart murmur	❑ tuberculosis	❑ stomach ulcers	❑ thyroid disease	
❑shortness of breath		❑ cancer	❑ arthritis	❑ drug/alcohol dependency	

16. Are there any conditions or diseases not listed above that you have or have had? If so, please explain.
❑ YES ❑ NO

17. Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease)
❑ YES ❑ NO ❑ NOT SURE/MAYBE

18. Do you smoke or chew tobacco products?
❑ YES ❑ NO

19. Are you nervous during dental treatment?
❑ YES ❑ NO

20. Women only: Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date?
❑ YES ❑ NO

OFFICE POLICY, COLLECTION, USE & DISCLOSURE OF PERSONAL INFORMATION

By signing below I have reviewed the displayed privacy policy which explains how our office will use my personal information. I understand that this office has a Privacy Code that can be seen at any time. I agree that Dr Weaver and Associates can collect, use, and disclose personal information about myself as set out in the office's privacy policy.
I understand that I am giving my consent to allow Dr Weaver and Associates to send me emails to the email address I have provided. I also understand that I may withdraw my consent at any time by contacting the office directly.
I fully understand the office policy regarding dental insurance and that I am responsible for payment for treatment rendered. All fees are payable, in full, by the patient or parent/guardian at the time the service is provided regardless of any dental insurance coverage. It is your responsibility to confirm your expected reimbursement with your insurance company.

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

PATIENT/PARENT/GUARDIAN SIGNATURE: **DATE:**

DENTIST SIGNATURE: **DATE:**