MEDICAL HISTORY QUESTIONNAIRE

Patient Name ____ Age _________________Date________________
Occupation (if retired, past occupation)____

If you had any serious illness, operation, or hospitalization, please explain:
____

If you are taking any **prescription** or **over-the-counter medication**, please list all medications and the conditions for which you are taking them in the space provided:

Rx:	Condition:	Rx:	Condition:
Rx:	Condition:	Rx:	Condition:
Rx:	Condition:	Rx:	Condition:
Rx:	Condition:	Rx:	Condition:

- Are you currently receiving **Bisphosphonate** (Fosamax) treatment or have in the past? ___ *Yes* ___ *No*

Your Pharmacy name and telephone # ____

Allergies?

- **To latex:** ___ *Yes* ___ *No* **To iodine?** ___ *Yes* ___ *No*
- **To medications?** ___ *Yes* ___ *No* If Yes - please list: _____________________________________

Women: Are you pregnant or nursing? ***Yes*** ***No***

Do you currently or have you ever had any of the following medical conditions?
(Please circle where appropriate)

Yes ***No*** **Heart disease** - please check where appropriate:

____Angina ____Heart attack ____Rheumatic heart disease
____Artificial valves ____High blood pressure ____Rhythm problems
____Congestive heart failure ____Mitral valve prolapse
____Heart murmur ____Pace maker

Premedication needed? ***Yes*** ***No***

Yes ***No*** **Joint replacement?**

Premedication needed? ***Yes*** ***No***

Yes ***No*** AIDS / HIV infection

Yes ***No*** Hepatitis? If so, what type? _____________

Yes ***No*** Alcohol / drug abuse

Yes ***No*** Anxiety

Yes ***No*** Colitis / ulcers

Yes ***No*** Arthritis

Yes ***No*** Asthma / Difficulty breathing / Emphysema

Please turn page over

Yes ***No*** Bleeding problems

Yes ***No*** Diabetes

Yes ***No*** Cancer / chemotherapy / radiation therapy

Yes ***No*** Epilepsy / seizures

Yes ***No*** Depression

Yes ***No*** Glaucoma

Yes ***No*** Herpes / fever blisters

Yes ***No*** Kidney disease

Yes ***No*** Anemia

Yes ***No*** Liver disease

Yes ***No*** Sinus problems

Yes ***No*** Stroke

Yes ***No*** Thyroid problems

Yes ***No*** Tuberculosis

Other ____

Physician's name ______________________________ Date of last physical exam ____________________
Phone (   ) ______________________________

To the best of my knowledge, the above information is complete and accurate.

Patient signature ____ Date ______________________

Signature of Parent or Guardian (If the patient is a minor) ____

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Information about the tooth / teeth to be evaluated today:

Your pain:
___ No pain ____ Swelling ___ Spontaneous ___ Tingling
___ Dull ___ Localized to one tooth ___ Sensitive to cold / hot / sweet (circle)
___ Sharp ___ Non-localized ___Sensitive to chewing / pressure
___ Worse at certain times of the day? When? ________________ ___ Radiating to: _________________

How long have you been in pain? ____
What makes the pain better? ____

Condition of the tooth: ___ Decay ___ Broken (missing a piece or filling) ___ Cracked

___ **Recent dental work** done on the tooth / teeth? What? ____

Comments: ____
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