## ***MEDICAL QUESTIONNAIRE***

Name_____

Correct answers to the following questions will allow us to treat you so there WILL NOT be an emergency. However, if an emergency situation does arise, this information will help insure proper treatment. Your medical history is strictly confidential.

1. Do you currently have a personal physician? ___No ___Yes Name_____
   Date of last medical exam_____

2. Do you have any current medical problems? ___ No ___ Yes
   If so, what? _____
   Are you under the care of a physician for this? ___ No ___ Yes

3. Are you taking any medications? ___ No ___ Yes
   List Medications: _____for_____
   _____for_____
   _____for_____
   _____for_____

4. Do you use any tobacco products? ____No ____ Yes Which type? Cigarettes: ____ Chewing Tobacco: ____

5. Do you have any ALLERGIES or ADVERSE REACTIONS to:

| | | | |
|---|---|---|---|
| Penicillin | ___ No ___ Yes | Codeine | ___ No ___ Yes |
| Local Anesthetic | ___ No ___ Yes | Erythromycin | ___ No ___ Yes |
| Aspirin | ___ No ___ Yes | Latex | ___ No ___ Yes |

Other_____

6. Have you ever had any of the following HEART PROBLEMS?

| | | | |
|---|---|---|---|
| Heart Murmur | ___ No ___ Yes | Heart Surgery | ___ No ___ Yes |
| Heart Attack | ___ No ___ Yes | Pacemaker | ___ No ___ Yes |
| Angina | ___ No ___ Yes | Rheumatic fever | ___ No ___ Yes |
| Mitral Valve Prolapse | ___ No ___ Yes | Artificial Heart Valve | ___ No ___ Yes |

7. Do you have any artificial joints (hip, knee)? ___ No ___ Yes

8. Have you ever been premedicated with antibiotics prior to dental treatment? ___ No ___ Yes

9. Have you ever had:

| | | | |
|---|---|---|---|
| High Blood Pressure | ___ No ___ Yes | HPV | ___ No ___ Yes |
| Hepatitis | ___ No ___ Yes | HIV Positive | ___ No ___ Yes |
| Anemia | ___ No ___ Yes | AIDS | ___ No ___ Yes |
| Asthma | ___ No ___ Yes | Epilepsy/Seizure | ___ No ___ Yes |
| Lung Problems | ___ No ___ Yes | Abnormal bleeding | ___ No ___ Yes |
| Tuberculosis | ___ No ___ Yes | Diabetes | ___ No ___ Yes |
| Osteoporosis | ___ No ___ Yes | Glaucoma | ___ No ___ Yes |

10. Have you been vaccinated against HPV? ___ No ___ Yes

11. Do you have any other disease or medical problem? ___ No ___ Yes

12. FEMALES: Are you pregnant? ___ No ___ Yes Do you take birth control pills? ___ No ___ Yes

Comments: _____

_____

The above information is accurate and complete to the best of my knowledge. I will not hold the dentist responsible for errors or omissions I have made. I will inform the dentist at each visit of any change in my health history or medications.

Signed: _____ Date: _____