Date: _____ **Name:** _____ **DOB:** _____

Medical History Questionnaire

Questions	***Answers***
Thank you for selecting our team! We will strive to provide you with the best possible care. To help us meet your dental needs, please answer the following questions. If you need assistance, please ask - we will be happy to help.	
What is the approximate date of your last doctor's visit?	
If you have a physician or family doctor, what is his / her phone number?	
How do you rate your current physical health?	Good
	Fair
	Poor
Are you under medical treatment now?	Yes
	No
Have you been hospitalized for any surgical operation or serious illness within the last 5 years?	Yes
	No
Are you taking any medication(s) including non-prescription medicine?	Yes
	No
Have you ever taken prescription medications for weight loss (diet pills)? If yes, did you take any of the following:	No
	Fen-Phen (Fenfluramine-Phentermine)
	Pondimen (Fenfluramine)
	Redux (Dexfenfluramine)
	Other
	Don't remember
Do you have a persistent cough or throat clearing not associated with a known illness, lasting more than 3 weeks?	Yes
	No
Do you have or have you had any of the following?	High blood pressure
	Low blood pressure
	Heart attack
	Rheumatic fever
	Heart disease
	Pacemaker
	Heart murmur
	Angina
	Chest pains
	Stroke
	Arthritis
	Swollen ankles
	Joint replacement or implant
	Respiratory problems
	Asthma
	Hay fever / Allergies

Date: _____ **Name:** _____ **DOB:** _____

Medical History Questionnaire

Questions	***Answers***
Do you have or have you had any of the following?	Thyroid problems
	Diabetes
	Kidney diseases
	Liver disease
	Stomach troubles / Ulcers, Colitis
	Fainting / Seizures
	Epilepsy / Convulsions
	Easily winded
	Frequently tired
	Hemophilia, abnormal bleeding
	AIDS or HIV
	Leukemia
	Anemia
	Emphysema
	Cancer
	Chemotherapy
	Radiation Therapy
	Hepatitis / Jaundice
	Sexually transmitted diseases (STD)
	Tuberculosis (TB)
	Glaucoma
	Recent weight loss
	Mitral Valve Prolapse
	Other
Are you allergic to or have you had any reactions to the following?	Local anesthetics (e.g. Novocain)
	Sedatives, dental anesthetics
	Penicillin or any other antibiotics
	Aspirin
	Erythromycin
	Tetracycline
	Codeine
	Sulfa drugs
	Barbiturates
	Iodine
	Any metals (e.g. nickel, mercury, etc.)
	Latex rubber
	Other
Do you have frequent headaches?	Yes
	No
Are you wearing contact lenses?	Yes
	No
Do you use controlled substances?	Yes

Date: _____ **Name:** _____ **DOB:** _____

Medical History Questionnaire

Questions	***Answers***
Do you use controlled substances?	No
Women only: Are you pregnant or think you may be pregnant?	Yes
	No
Women only: If you are pregnant, how many weeks?	
Women only: Are you nursing?	Yes
	No
Women only: Are you taking oral contraceptives (birth control pills)?	Yes
	No

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such medical care to third payors and/or health practitioners. I authorize and request my insurance company to pay directly to the doctor or doctor group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature: _____