Medical History Questionnaire

Patient's Name: ____ Date: _____________Age:________

Dentist: ______________________________________Phone#_________________________________

Address: ____

Primary Care Physician: _________________________Phone#_________________________________

Address: ____

Last Physical Examination: ___________________________ Results of Last Physical: _____________

Other Physicians (specialists) ____

Have you had any major operations, hospitalizations or illnesses? If yes, list with dates.

Yes No____

Are you currently being treated by a medical doctor? If yes, for what reason?

Yes No____

Are you taking any prescription medicine at the present time? If yes, please list.

Yes No____

Are you taking any "over the counter" medicine at this time? If yes, please list.

Yes No____

Are you allergic to any medications? If yes, what'?

Yes No____

Have you had abnormal bleeding with extractions, surgery or trauma?

Yes No____

Do you have any blood conditions (anemia)?

Yes No____

Are you aware of any heart conditions?

Yes No____

Are you aware of any respiratory or breathing problems?

Yes No____

Are you aware of any kidney or liver problems?

Yes No____

Do you have hearing or vision concerns (glaucoma, hearing aid, glasses, cataracts)

Yes No____

Has anyone in your family had diabetes, heart disease, cancer? If yes, who?

Yes No____

Do you have sinus problems or any allergies? If yes, please list.

Yes No____

Do you use tobacco products? If yes, please list type, amount and duration.

Yes No____

Do you have problems with other organ systems (Kidney, Liver, G.I.)

Yes No____

Are you or could you be pregnant? Yes No

Are you currently taking birth control pills? Yes No

Please describe any other condition or information we should be aware of.

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Would you like to speak to the doctor privately about any problem?

Yes No____

Patient Signature____

Date______________________

Doctor Signature____

Date______________________