MEDICAL HEALTH QUESTIONAIRE

PERSONAL INFORMATION

Last Name:_____FirstName_____MI____Preferred Name_____

Health History

Physician's Name_____ Physician's Number_____
Date of last visit ____/____/____

Please **CIRCLE** Y(yes) or N(no) to indicate if had any of the following and if yes, provide date

Y N Abnormal bleeding w/ Extraction/surgery
Y N Aids
Y N Anemia
Y N Arthritis, Rheumatism
Y N Artificial Heart Valves
Y N Artificial Joint
Y N Asthma
Y N Autoimmune Disease
Y N Back Problems
Y N Blood Disease
Y N Cancer
Y N Chemical Dependency
Y N Circulatory problems
Y N Chemotherapy
Y N Cholesterol
Y N Congenital Heart Lesions
Y N Cortisone Treatment
Y N Cough, Persistent or Bloody
Y N Diabetes
Y N Emphyzema
Y N Epilepsy
Y N Fainting/Dizziness
Y N Glauacoma
Y N Headaches
Y N Heart Murmur
Y N Heart Problems
Y N Hepatitis: Type____
Y N Herpes
Y N High Blood Pressure
Y N HIV Positive
Y N Jaundice
Y N Jaw Pain
Y N Kidney Disease
Y N Liver Disease
Y N Low Blood Pressure
Y N Mitral Valve Prolapse
Y N Nervous Problems
Y N Neurological Problems
Y N Osteoporisis
Y N Pace Maker
Y N Prosthetic Device
Y N Psychiatric Care
Y N Radiation Treatment
Y N Recent Surgeries
Y N Sinus Troubles
Y N Skin Rash
Y N Stroke
Y N Swelling of feet or ankles
Y N Swollen Neck Glands
Y N Thyroid Problems
Y N Tonsilitis
Y N Tuberculosis
Y N Venereal Disease
Y N Weight loss, unexplained

Women Only:
Y N Oral Contraceptives
Y N Are you Pregnant?
Due Date:____/____/_____
Y N Are you nursing?

Medications

List all medications you are currently taking:_____

Do you premedicate before dental visits? Y N

If So, name of antibiotic taken:_____

Allergies

Y N Aspirin
Y N Barbituates
Y N Codeine
Y N Latex
Y N Local Anesthetic
Y N Sulfa
Y N Penicillin
other antibiotics: _____
Other:_____
_____

Signature of Patient/Legal Guardian:_____ **Date____/____/_____**
Signature of Doctor_____

Pharmacy information: Name_____ **Phone number**_____