MEDICAL HISTORY QUESTIONNAIRE

Today's date _____

Name _____ Date of Birth (MM/DD/YYY)_____

Identifies as: Female ☐ Male ☐ Other ☐ (For office use only: CC # _____)

Measured Height _____ Measured Weight_____ (For office use only: BMI _____)

Phone: Home_____ Cell_____ Work_____

Email _____

Home Address: _____

Mailing Address: (same as home ☐)_____

City / Province _____ Postal code _____

Person to notify in case of emergency _____

Relationship to you _____ Their Phone # _____

Parent or Legally Authorized Representative (If applicable): _____

HEALTH HISTORY **YES**

Have you ever had sedation? (ex., Intravenous (IV) or Oral) ☐

If yes, when? _____

Any complications? If yes, please explain _____

Has a family member had Sedation or Anesthetic complications? ☐

If yes, please explain _____

Are you being treated for any medical conditions now or in the past 2 years? ☐

If yes, please explain: _____

Date of last visit to physician _____

Last complete Medical Exam _____

Have you ever had a serious illness, accident, or required extensive medical care? ☐

If yes, please explain _____

Have you been hospitalized in the last 5 years? ☐

If yes, please explain _____

Are you taking any prescription or non-prescription drugs? ☐

If yes, name and dose, and how long_ _____

_____

_____

Have you ever had a reaction to any drug(s) or have been advised against taking any kind of medication? ☐

If yes, please list medications: _____

Do you have any sensitivities or allergies? ☐

If yes, please explain: _____

MEDICAL HISTORY QUESTIONNAIRE

Indicate which of the following you presently, or have ever had:

CARDIOVASCULAR — YES

- High / Low Blood Pressure ☐
- Heart Disease/Attack ☐
- Heart Surgery ☐
- Angina/Chest Pain ☐
- Congestive Heart Failure/ Pulmonary Edema ☐
- Fainting / Dizzy Spells ☐
- Heart Murmur ☐
- Heart Rhythm Disorder ☐
- Pacemaker / AICD ☐
- Infective Endocarditis ☐
- Congenital Heart Lesions ☐
- Rheumatic Fever ☐
- Mitral Valve Prolapse ☐
- Artificial Heart Valve ☐
- Anemia ☐
- Circulation Problems ☐
- Shortness of Breath ☐

RESPIRATORY

- Lung Disease ☐
- Asthma ☐
- Emphysema ☐
- Sleep Apnea ☐
- CPAP Machine ☐
- Blood in Sputum ☐
- Persistent Cough ☐
- Sinus Trouble ☐

EXERCISE TOLERANCE — YES

- Shortness of breath walking 2 Flights of Stairs ☐
- Chest pain with exercise ☐
- Joint pain with exercise ☐

NEUROLOGICAL

- Frequent Earaches ☐
- Stroke/TIA ☐
- Alzheimer Disease / Dementia ☐
- Epilepsy / Seizures ☐
- Mental or Nervous Disorder ☐
- Psychiatric Treatment ☐
- Balance Problems ☐
- Cerebral Palsy ☐
- Frequent Headaches/Migraines ☐
- Head or Neck Injuries ☐
- Hearing Difficulties ☐
- Glaucoma ☐
- Impaired Vision ☐
- TMJ Disorder ☐
- Temperature Intolerance ☐

INFECTIOUS

- Hepatitis A / B / C ☐
- Herpes ☐
- HIV Positive / AIDS ☐
- Tuberculosis ☐

ENDOCRINE/AUTOIMMUNE/OTHER — YES

- Hyper / Hypo Glycemia ☐
- Diabetes ☐
- Insulin use ☐
- Thyroid Disease ☐
- Cortisone/Steroid Therapy ☐
- Liver Disease ☐
- Jaundice ☐
- Kidney Disease ☐
- Blood Disorder ☐
- Easily Bleed or Bruising ☐
- Frequent Nose Bleeds ☐
- Hemophilia ☐
- Heartburn ☐
- Stomach Ulcers ☐
- Cancer ☐
- Change in Appetite ☐
- Radiation/Chemotherapy ☐
- Sickle Cell Disease ☐
- Organ Transplant ☐
- Arthritis / Rheumatism ☐
- Artificial Joints ☐
- Implanted Medical Device ☐
- Malignant Hyperthermia ☐
- Motion Sickness ☐

Other Medical concerns not listed:

SOCIAL

- Smoking / Vape: Tobacco ☐ If yes, how much per day ____
- Marijuana ☐ If yes, how much per day ____
- Recreational Drug use ☐ If yes, how much per day ____
- Alcohol ☐ If yes, how much per day ____
- Have you received treatment for alcohol or drug use? ☐

NO to ALL Questions ☐

Reviewed by Dentist_____

YES

Do you currently have, or have you had in the past, any disease, condition, or problem not listed? ☐

If yes, please explain: _____

_____

Is there any problem or medical condition that you wish to discuss in Private only? ☐

Are you pregnant or suspect you might be? ☐

Anticipated delivery date _____

Are you breast feeding? ☐

Family Doctor: _____ **Phone:**_____

Any other Doctors:_____ **Phone:**_____

_____ **Phone:**_____

_____ **Phone:**_____

NOTE: IT IS IMPORTANT THAT ANY CHANGES IN YOUR HEALTH STATUS BE REPORTED TO OUR OFFICE

I, the undersigned, certify that all the medical and dental information provided is true to the best of my knowledge, and I have not knowingly omitted any information that is required for my dental care.

In addition, I understand that upon receiving treatment in the form of a consultation or surgical procedure that payment must be made in full at the time of the visit, which includes any balances that may not be covered by your insurance.

In addition, I understand that this office may directly bill my insurance company or companies on my behalf as a courtesy for me, for direct reimbursement from my insurance company or companies if applicable.

Signature _____ Date _____

☐ Patient ☐ Parent ☐ Legally Authorized Representative

Reviewed by Dentist _____ Date _____

Reviewed by Anesthesiologist _____ Date _____