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 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_____

   Wellness Providers (Chiropractor, Functional Medicine, etc.): Name(s)_____
   _____

2. Do you have any current medical problems? ___ No ___ Yes
   If so, what? _____

3. Medications: _____for_____ Supplements: _____
   _____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_____		Food Sensitivities (Dairy, Corn, Gluten, etc.) _____	

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	Glaucoma	___ No ___ Yes
Hepatitis	___ No ___ Yes	HIV / AIDS	___ No ___ Yes
Anemia	___ No ___ Yes	Cancer	___ 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	Autoimmune Condition	___ No ___ Yes

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

11. 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: _____