Medical questionnaire

Patient last name: _____ First name: _____ Date of birth: _____

Address: (no., street) _____ (city) _____ (postal code) _____

Telephone: (1) _____ (2) _____ Email: _____

Occupation: _____ In case of emergency: _____

Name and specialty of physician: _____

Date and reason for last medical examination: _____

How do you rate your general health? ☐ excellent ☐ good ☐ fair ☐ poor

Have you ever had:	**YES**	**NO**
1. Hospitalization for an injury or illness	☐	☐
2. An allergic reaction to:	☐	☐
Aspirin, ibuprofen, acetaminophen	☐	☐
Penicillin	☐	☐
Erythromycin	☐	☐
Tetracycline	☐	☐
Codeine	☐	☐
Local anesthesia	☐	☐
Fluoride	☐	☐
Metals (cobalt, nickel, stainless steel, gold, etc.)	☐	☐
Latex	☐	☐
Other medications _____	☐	☐
3. Heart disease, heart problems _____	☐	☐
4. Taste/smell problems _____	☐	☐
5. Rheumatic fever _____	☐	☐
6. Scarlet fever _____	☐	☐
7. High blood pressure _____	☐	☐
8. Low blood pressure _____	☐	☐
9. CVA (stroke) _____	☐	☐
10. Artificial prosthesis (heart valve, bypass) _____	☐	☐
11. Anemia or other blood disorders _____	☐	☐
12. Prolonged bleeding _____	☐	☐
13. Emphysema _____	☐	☐
14. Tuberculosis _____	☐	☐
15. Asthma _____	☐	☐
16. Sleep or breathing disorders (snoring, sinus) _____	☐	☐
17. Kidney disease _____	☐	☐
18. Liver disease _____	☐	☐
19. Jaundice _____	☐	☐
20. Thyroid or parathyroid gland disease _____	☐	☐
21. Hormonal deficiency _____	☐	☐
22. Cholesterol (hypercholesterolemia) _____	☐	☐
23. Diabetes _____	☐	☐
24. Stomach or duodenal ulcer _____	☐	☐

	YES	**NO**
25. Digestive problems (acid reflux) _____	☐	☐
26. Arthritis _____	☐	☐
27. Glaucoma _____	☐	☐
28. Contact lenses _____	☐	☐
29. Head or neck injuries _____	☐	☐
30. Epilepsy or seizures _____	☐	☐
31. Neurological problems _____	☐	☐
32. Viral infections and cold sores _____	☐	☐
33. Lump or swelling in the mouth _____	☐	☐
34. Hives, hay fever _____	☐	☐
35. Venereal diseases _____	☐	☐
36. Hepatitis, which type _____	☐	☐
37. HIV-AIDS _____	☐	☐
38. Tumor, abnormal lumps _____	☐	☐
39. Radiation therapy _____	☐	☐
40. Chemotherapy _____	☐	☐
41. Emotional problems _____	☐	☐
42. Psychiatric treatments _____	☐	☐
43. Antidepressant medication _____	☐	☐
44. Alcoholism - drug addiction _____	☐	☐
Are you:		
45. Currently under treatment for another disease	☐	☐
46. Aware of a change in your general health condition _____	☐	☐
47. Treated for osteoporosis-osteopenia _____	☐	☐
48. Often tired or exhausted _____	☐	☐
49. Subject to frequent headaches _____	☐	☐
50. A smoker or former smoker _____	☐	☐
51. Often unhappy or depressed _____	☐	☐
52. WOMAN: taking birth control pills _____	☐	☐
53. WOMAN: pregnant _____	☐	☐
54. MAN: do you have prostate disorders _____	☐	☐

Describe any other medical treatment or surgery that may affect your dental treatment

_____

List all medications, supplements or vitamins taken during the past 2 years

Medication	Reason	Medication	Reason

Ask for an additional sheet if you take more than 6 medications.

PLEASE notify us of any changes in your medical history or medication.

Patient signature _____ Date _____

Dentist signature _____ Date _____