# MEDICAL HISTORY QUESTIONNAIRE

# DR. ED HOBEN

**The following information is required to enable us to provide you with the best possible dental care.**
**All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.**

NAME: MR./MRS./MS./MISS/DR. _____

DATE OF BIRTH (DAY/MONTH/YEAR): _____/_____/_____

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|---|---|
| **IN CASE OF EMERGENCY, WE SHOULD NOTIFY:**<br>NAME: _____<br>RELATIONSHIP _____<br>PHONE OR ADDRESS: _____ | (1) NAME OF MEDICAL SPECIALIST: _____<br>AREA OF SPECIALITY: _____<br>PHONE OR ADDRESS: _____ |
| NAME OF FAMILY DOCTOR: _____<br>DAY-TIME PHONE: _____ | (2) NAME OF MEDICAL SPECIALIST: _____<br>AREA OF SPECIALITY: _____<br>PHONE OR ADDRESS: _____ |

**1.** Are you being treated for any medical condition at the present or have been treated within the past year? If so, why? ☐ YES ☐ NO ☐ NOT SURE

2. When was your last medical checkup?

3. Has there been any change in your general health in the past year? If yes, please explain. ☐ YES ☐ NO ☐ NOT SURE

4. Do you have any allergies? If you answered yes, please list using the categories below: ☐ YES ☐ NO ☐ NOT SURE

a) medications
b) latex/rubber products
c) other e.g. hay fever, foods

5. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list. ☐ YES ☐ NO ☐ NOT SURE

**PLEASE TURN OVER** →

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain. ☐ YES ☐ NO ☐ NOT SURE

7. Do you have or have your ever had asthma? ☐ YES ☐ NO ☐ NOT SURE

8. Do you have or have you ever had any heart or blood pressure problems? ☐ YES ☐ NO ☐ NOT SURE

9. Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever? ☐ YES ☐ NO ☐ NOT SURE

10. Do you have a prosthetic or artificial joint? ☐ YES ☐ NO ☐ NOT SURE

11. Have you ever been advised by your doctor to take antibiotics before dental treatment? If yes, please explain. ☐ YES ☐ NO ☐ NOT SURE

12. Do you have any conditions or therapies that could affect your immune system? If yes, please explain (e.g. leukemia, AIDS,HIV infection, radiotherapy, chemotherapy) ☐ YES ☐ NO ☐ NOT SURE

13. Have you ever had hepatitis, jaundice or liver disease? ☐ YES ☐ NO ☐ NOT SURE

14. Do you have a bleeding problem or bleeding disorder? ☐ YES ☐ NO ☐ NOT SURE

15. Have you ever been hospitalized for any illnesses or operations? If yes, please explain. ☐ YES ☐ NO ☐ NOT SURE

16. Do you have or have you ever had any of the following? Please check.

| | | | | | |
|---|---|---|---|---|---|
| ☐ chest pain, angina | ☐ shortness of breath | ☐ prosthetic heart valve | ☐ steroid therapy | ☐ seizures (epilepsy) | ☐ drug/alcohol dependency |
| ☐ heart attack | ☐ pacemaker | ☐ lung disease | ☐ diabetes | ☐ kidney disease | ☐ diet pill therapy |
| ☐ stroke | ☐ cancer | ☐ tuberculosis | ☐ stomach ulcer | ☐ thyroid disease | ☐ arthritis |

17. Are there any conditions or diseases not listed above that you have or have had? If so, what? ☐ YES ☐ NO ☐ NOT SURE

18. Are there any diseases or medical problems that run in your family? If yes, please explain. (e.g. diabetes, cancer or heart disease) ☐ YES ☐ NO ☐ NOT SURE

19. Do you smoke or chew tobacco products? ☐ YES ☐ NO ☐ NOT SURE

**20. For women only:** Are you breast-feeding or pregnant? If pregnant, what is the expected delivery date? ☐ YES ☐ NO ☐ NOT SURE

**To the best of my knowledge, the above information is correct:**

**PATIENT/PARENT/GUARDIAN SIGNATURE:** _____ **DATE:** _____

**DENTIST SIGNATURE:** _____ **DATE:** _____

**MEDICAL ALERT:** _____

**(To be filled in by office)**