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): _____/_____/_____

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

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? How many per day? ☐ 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)