Confidential Medical Questionnaire

Patient: Family Dr: Print date :

Created on :

Updated on :

Yes	No	Question
[ ]	[ ]	0. Have you ever been advised by a Doctor to take a premedication before your dental treatments?
[ ]	[ ]	1. Have you had a medical examination in the past year? (If it has been longer than one year please give ar approximate length of time in the note section to the right of the question.)
[ ]	[ ]	2. Are you presently under the care of a physician?
[ ]	[ ]	3. Have you ever been hospitalized and was surgery performed?
[ ]	[ ]	4. Have you recently or are you presently taking any prescription or non prescription drugs? (Please List medications in the note section located to the right of the question.)
[ ]	[ ]	5. Have you had any allergies to any drugs or medicines? ie: Penicillan, Sulfa. Please specify in the note section located to the right of the question.
[ ]	[ ]	6. Do you have any allergies? ie: hayfever (please specify in the note section located to the right of the question.)
[ ]	[ ]	7. Do you have a heart murrnur or mitral valve prolapse?
[ ]	[ ]	8. Do you have artificial joints or valves?
[ ]	[ ]	9. Do you experience shortness of breath or chest pain?
[ ]	[ ]	10. Do you bleed excessively from a cut or injury?
[ ]	[ ]	11. Do you bruise easily
[ ]	[ ]	12. Do your ankles, feet or hands swell?
[ ]	[ ]	13. Have you lost or gained weight lately?
[ ]	[ ]	14. Are you dependent on tobacco/alcohol or drugs?

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[ ][ ] 15. Do you have or have you had A.I.D.S/HIV?

[ ][ ] 16. Do you have or have you had Anemia?

[ ][ ] 17. Do you have or have you had Arthritis/Rheumatism?

[ ][ ] 18. Do you have or have you had Bronchitis?

[ ][ ] 19. Do you have or have you had Cancer?

[ ][ ] 20. Do you have or have you had Chemotherapy/Radiation?

[ ][ ] 21. Do you have or have you had Cortisone/Steroid?

[ ][ ] 22. Do you have or have you had Diabetes?

[ ][ ] 23. Do you have or have you had Epilepsy/Seizures?

[ ][ ] 24. Do you have or have you had Fainting or Dizzy spells?

[ ][ ] 25. Do you have or have you had Heart Disease or Attack?

[ ][ ] 26. Do you have or have you had Hepatitis A,B,C

[ ][ ] 27. Do you have or have you had Herpes?

[ ][ ] 28. Do you have or have you had High/Low Blood Pressure?

[ ][ ] 29. Do you have or have you had Kidney Disease?

[ ][ ] 30. Do you have or have you had Liver Disease?

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[ ][ ] 31. Do you have or have you had Lung Disease

[ ][ ] 32. Do you have or have you had Mental / Nervous Disorder

[ ][ ] 33. Do you have or have you had Mitral Valve Prolapse?

[ ][ ] 34. Do you have or have you had Rheumatic/Scarlet Fever?

[ ][ ] 35. Do you have or have you had Sinus trouble?

[ ][ ] 36. Do you have or have you had Stomache/Intestinal problems?

[ ][ ] 37. Do you have or have you had Stroke?

[ ][ ] 38. Do you have or have you had Thyroid Disease?

[ ][ ] 39. Do you have or have you had Tuberculosis?

[ ][ ] 40. Do you have or have you had Venereal Disease?

[ ][ ] 41. Is there anything that was not listed in this questionnaire that you think you should tell me about your health?

[ ][ ] 42. The Following Questions are Dental Related

[ ][ ] 43. Are you having any discomfort at this time? (if yes please specify in the note section located to the right of the question)

[ ][ ] 44. When was your last Dental Visit? (please specifiy in the note section located to the right of the question)

[ ][ ] 45. Do your gums feel tender or swollen?

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[ ][ ] 46. Have you ever had any complications with Local(freezing) or general anaesthetic?

[ ][ ] 47. Are you aware of any lumps or swelling in your mouth?

[ ][ ] 48. Are you satisfied with the appearance of your teeth?

[ ][ ] 49. Are you anxious about dental treatments?

[ ][ ] 50. Do you currently experience loose teeth?

[ ][ ] 51. Do you currently experience Sensitive teeth?

[ ][ ] 52. Do you currently experience Ear ache?

[ ][ ] 53. Do you currently experience Headache?

[ ][ ] 54. Do you currently experience Spaced or crooked teeth?

[ ][ ] 55. Do you currently experience Bleeding gums?

[ ][ ] 56. Do you currently experience Bad breath?

[ ][ ] 57. Do you currently experience Neck Pain?

[ ][ ] 58. Do you currently experience unexplained nosebleed?

[ ][ ] 59. Do you currently experience unsatisfactory Dentures?

[ ][ ] 60. Do you currently experience Sore gums?

[ ][ ] 61. Do you currently experience popping or clicking in the jaw joints?

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[ ][ ] 62. Do you currently experience missing teeth?

[ ][ ] 63. Do you have a sensitive gag reflex?

[ ][ ] 64. Is there any chance that you might be pregnant?

Signature:_____
Date:_____