Infinity Dental
8940 W. Tropicana Ave.
Las Vegas, NV. 89147
702-248-4448

Medical Health Questionnaire

Name:_____ **Preferred Name**:_____ **Birth Date:** _____

Current Address: _____**Zip**:_____**Phone #**:_____

Emergency Contact:(Name and Relationship) _____**Phone #**:_____

Pharmacy Name and Phone Number/Location: _____

Height _____ **Weight** _____

1. Are you now under the care of a physician? Yes No
   A. If so, what is the condition being treated? _____
2. Name and telephone number of physician _____
3. Have you had any serious illness, operation or been hospitalized? Yes No
   A. If yes, what was the problem and when? _____
4. Do you drink alcoholic beverages? Yes No
5. Have you used any recreational drugs in the last six months? Yes No
6. History of drug abuse? Yes No
7. History alcohol abuse? Yes No
8. Do you smoke/chew/vape? (Circle all that apply) Yes No
   Please indicate how much and for how long? _____

9. Are you for any reason required to take a prophylactic-antibiotic (Pre-Medication) prior to appointments?

HAVE YOU HAD OR DO YOU CURRENLY HAVE ANY OF THE FOLLOWING CONDITIONS:

	Yes	No
Heart Condition		
High Blood Pressure	___	___
Low Blood Pressure	___	___
Angina/Chest Pain	___	___
Fainting	___	___
Irregular Heart Beat	___	___
Heart Attack	___	___
Heart Bypass	___	___
Heart Pacemaker	___	___
Stroke	___	___
Rheumatic Fever/ Heart Valve Damage	___	___
Heart Valve Replacement	___	___
Liver Disease		
Hepatitis-circle one A B C	___	___
Breathing/Lung Condition		
Asthma	___	___
Allergies/Hay Fever	___	___
Emphysema	___	___
Breathing Difficulties	___	___
Snoring/Sleep Apnea	___	___
Tuberculosis	___	___

	Yes	No
Immunosupressed/Blood Disease		
HIV Positive	___	___
Aids	___	___
Sexually Transmitted Disease	___	___
Delay in Healing	___	___
Organ Condition/Disease		
Pancreas/Diabetes	___	___
Kidney/Dialysis	___	___
Eyes/Glaucoma	___	___
Thyroid	___	___
Neurologic/Epilepsy	___	___
Cancer		
Location: _____ Year_____		
Surgery	___	___
Radiation Treatment	___	___
Chemo Therapy	___	___
Joint Condition		
Clicking/Pain in jaw joints when eating	___	___
Arthritis	___	___
Artificial Hips/Knees/ Shoulders/Pins	___	___
If Yes, When? _____		

10. Have you had abnormal bleeding associated with previous extractions, surgery or trauma? Yes No
    A. Do you bruise easily? Yes No
    B. Have you ever required a blood transfusion? Yes No
11. Have you had surgery or x-ray treatment for a tumor, growth, or other condition in your mouth or lips? Yes No
    If yes, date _____
12. Are you taking any drug or medicine? Yes No
    If yes, list all medication(s) _____

_____

13. Are you taking any of the following?

A. Antibiotics or sulfa drugs	Yes	No
B. Anticoagulants (blood thinners)	Yes	No
C. Medicine for high blood pressure	Yes	No
D. Cortisone (steroids)	Yes	No
E. Tranquilizers	Yes	No
F. Aspirin	Yes	No
G. Insulin, Tolbutamid	Yes	No
H. Digitalis or drugs for heart problems	Yes	No
I. Nitroglycerin	Yes	No

J. Other _____

14. Are you allergic or have you reacted adversely to

A. Penicillin or other antibiotics	Yes	No
B. Latex	Yes	No
C. Aspirin	Yes	No
D. Local anesthetic	Yes	No
E. Barbiturates, codeine, sedatives, sleeping pills	Yes	No
F. Iodine	Yes	No
G. Sulfa drugs	Yes	No

H. Other _____

15. Have you had any adverse reaction associates with previous dental treatment? Yes No
    If yes, explain _____
16. Have you had any adverse reaction associated with previous medical problems? Yes No
    If yes, explain _____

Woman Only - Items 17-19:

17. Are you pregnant?	Yes	No
18. Are you nursing?	Yes	No
19. Are you taking birth control medication?	Yes	No
20. Mental health problems?	Yes	No
21. Have you had any disease, serious illness/surgery condition or problem not listed above?	Yes	No

If yes, explain _____

22. Have you been on any IV Bisphosphonates for chemotherapy, i.e., **Zometa**, or Oral Bisphosphonates in the last 5 years for osteoporosis, i.e., **Fosamax** or **Actonel**, etc.? Yes No
    If yes, explain _____

I have filled out this health form completely and I have advised the doctor of all medical conditions of which I am aware.	**I have reviewed and understand the Patient's health history as documented above.**
X_____	**X**_____
Patient/Guardian Signature **Date**	**Doctor Signature** **Date**

To Be Completed at Next Visit: Any changes in your health history since your last visit? Yes / No If Yes, Please indicate below:

_____

_____

X_____	X_____
Signature Date	Doctor Signature Date