Medical Health Questionnaire

Name:______________________________________ **Preferred Name**:______________________ **Date of Birth**________________

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/alcohol/substance abuse? (Circle all that apply) Yes No

8. Do you smoke/chew/vape? (Circle all that apply) Yes No
9. Are you for any reason required to take a prophylactic-antibiotic (Pre-Medication) prior to appointments? Yes No
10. Do you suffer from headaches or facial pain? Yes No
11. Are you interested in Therapeutic BOTOX® or Dermal Fillers? Yes No
12. Have you been vaccinated for COVID 19? If Yes, Which? ____
    (You may decline to respond, this is only to update our medical records)

Heart Condition	**YES**	**NO**
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	___	___

Immunosuppressed/Blood Disease	**YES**	**NO**
HIV Positive	___	___
Aids	___	___
Sexually Transmitted Disease	___	___
Delay in Healing	___	___
Organ Condition/Disease		
Pancreas/Diabetes	___	___
Kidney/Dialysis	___	___
Eyes/Glaucoma	___	___
Thyroid	___	___
Neurologic/Epilepsy	___	___
Cancer		
Type:/Year _______________________________		
Surgery	___	___
Radiation Treatment	___	___
Chemo Therapy	___	___
Joint Condition		
Clicking/Pain in jaw joints when eating	___	___
Arthritis	___	___
Artificial Hips/Knees/ Shoulders/Pins	___	___

12. 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
13. 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 ________________________

14. 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____

17. **Woman Only** - (Circle all that apply) Are you pregnant, nursing, or taking birth control medicine? Yes No
18. Mental health problems? Yes No
19. Have you had any disease, serious illness/surgery condition or problem not listed above? Yes No
If yes, explain____

20. 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. X____ Patient/Guardian Signature Date	I have reviewed and understand the Patient's health history as documented above. X____ 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