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) _____

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