CARP FAMILY DENTISTRY

MEDICAL HISTORY QUESTIONNAIRE

MEDICAL ALERT

PERSONAL INFORMATION

Name:

Date of Birth (dd/mm/yy):

Address:

Home:

Mobile:

Work:

Email:

Occupation:

In case of emergency, we should notify:

Name:

Relationship:

Daytime Phone #

Medical Contacts

Family Doctor:

Phone #:

Address:

Medical Specialist:

Area of Speciality:

Phone #:

Address:

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.

1. When was your last dental visit?

2. Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why?

☐ Yes ☐ No ☐ Not Sure/Maybe

3. When was your last medical checkup?

4. Has there been any change in your general health in the past year? If yes, please explain.

☐ Yes ☐ No ☐ Not Sure/Maybe

5. Are you taking any medication, non-prescription drugs or herbal supplements of any kind? If yes, please list.

☐ Yes ☐ No ☐ Not Sure/Maybe

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.

☐ Yes ☐ No ☐ Not Sure/Maybe

7. Do you have any allergies? If you answered yes, please list using the categories below:

☐ Medication ☐ Latex/Rubber products ☐ Other (e.g. hayfever or foods

8. Do you have or have you ever had asthma?

☐ Yes ☐ No ☐ Not Sure/Maybe

9. Do you have or have you ever had any heart or blood pressure problems?

☐ Yes ☐ No ☐ Not Sure/Maybe

10. Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis)

☐ Yes ☐ No ☐ Not Sure/Maybe

11. Do you have a prosthetic or artificial joint

☐ Yes ☐ No ☐ Not Sure/Maybe

12. Have you ever had hepatitis, jaundice or liver disease

☐ Yes ☐ No ☐ Not Sure/Maybe

13. Do you have any conditions or therapies that could affect your immune system (e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy)?

☐ Yes ☐ No ☐ Not Sure/Maybe

14. Do you have a bleeding problem or bleeding disorder?

☐ Yes ☐ No ☐ Not Sure/Maybe

15. Have you been hospitalized for any illnesses or operation? If yes, please explain

☐ Yes ☐ No ☐ Not Sure/Maybe

16. Do you have or have you ever had any of the following? Please Check

☐ Chest pain, angina	☐ Mitral Valve Prolapse	☐ Pacemaker	☐ Steroid therapy	☐ Seizures (epilepsy)	☐ Heart murmur
☐ Heart attack	☐ Rheumatic fever	☐ Lung disease	☐ Diabetes	☐ Kidney disease	☐ Cancer
☐ Stroke	☐ Arthritis	☐ Tuberculosis	☐ Stomach ulcers	☐ Thyroid Disease	☐ Chemotherapy
☐ Osteoporosis Medication (e.g. Fosamax, Actonel)		☐ Drug\alcohol dependency		☐ Shortness of Breath	
☐ Radiation to the head or neck		☐ Problems with general anesthesia			

17. Are there any conditions or diseases not listed above that you have or have had? If so what?

☐ Yes ☐ No ☐ Not Sure/Maybe

18. Are there any diseases or medical problems that run in your family (e.g. diabetes, cancer or heart disease)

☐ Yes ☐ No ☐ Not Sure/Maybe

19. Do you smoke or chew tobacco products?

☐ Yes ☐ No ☐ Not Sure/Maybe

20. Are you nervous during dental treatment?

☐ Yes ☐ No ☐ Not Sure/Maybe

21. For women only:Are you breastfeeding or pregnant? If pregnant what is the expected delivery date?

☐ Yes ☐ No ☐ Not Sure/Maybe

To the best of my knowledge, the above information is correct:

Patient/Parent Guardian Signature

Date:

Dentist Signature

Date:

DENTIST'S NOTES