MEDICAL HISTORY QUESTIONNAIRE

chapel hill dental

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NAME: Mr./Miss/Mrs./Ms./Dr.

_____

DATE OF BIRTH (DAY/MONTH/YEAR): _____ / _____ / _____

ADDRESS (HOME):

_____

_____

_____

PHONE (HOME): _____

PHONE (WORK): _____

PHONE (MOBILE): _____

E-MAIL ADDRESS: _____

HOW DID YOU FIND US? (ex. internet, ad, driving by, referral, etc.)

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME: _____

RELATIONSHIP: _____

PHONE: _____

NAME OF PHYSICIAN: _____

CONTACT INFORMATION (IF KNOWN):

_____

_____

_____

REGULAR PHARMACY: _____

_____

IF REFERRED BY A FRIEND/RELATIVE, WHO SHOULD WE THANK?_____

THE FOLLOWING INFORMATION IS REQUIRED TO ENABLE US TO PROVIDE YOU WITH THE BEST POSSIBLE DENTAL CARE. ALL INFORMATION IS STRICTLY PRIVATE AND CONFIDENTIAL, 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.

PLEASE CIRCLE YOUR ANSWER

1. 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

_____

2. When was your last medical checkup? _____

_____

3. Has there been any change in your general health in the past year? If yes, please explain. YES NO NOT SURE

_____

Explain: _____

_____

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list. If unknown, please provide your pharmacy's name and location. YES NO NOT SURE

_____

_____

5. Do you have any allergies? If you answered yes, please list using the categories below: YES NO NOT SURE

a) medications:

b) latex/rubber products:

c) other (e.g. hayfever, foods):

_____

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain. YES NO NOT SURE

_____

Explain: _____

_____

7. Do you have or have you ever had asthma? YES NO NOT SURE

8. Do you have or have you ever had any heart or blood pressure problems? YES NO NOT SURE

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9. 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), a heart condition from birth (i.e. congenital heart disease) or a heart transplant? YES NO NOT SURE

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10. Do you have a prosthetic or artificial joint? YES NO NOT SURE

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11. 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

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12. Have you ever had hepatitis, jaundice or liver disease? YES NO NOT SURE

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13. Do you have a bleeding problem or bleeding disorder? YES NO NOT SURE

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14. Have you ever been hospitalized for any illness or operations? If yes, please explain. YES NO NOT SURE

Explain: _____

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15. Do you have or have you ever had any of the following? Please circle.

chest pain, angina	rheumatic fever	pacemaker	steroid therapy	seizures (epilepsy)	osteoporosis medications (e.g. Fosamax)	heart attack	mitral valve prolapse	lung disease	diabetes
kidney disease	stroke	tuberculosis	stomach ulcers	thyroid disease	shortness of breath	heart murmur	cancer	arthritis	drug/alcohol dependency

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16. Are there any conditions or diseases not listed above that you have or have had? If so, what? YES NO NOT SURE

Explain: _____

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17. Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer, heart disease) YES NO NOT SURE

Explain: _____

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18. Do you smoke or chew tobacco products? YES NO NOT SURE

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19. Are you nervous during dental treatments? YES NO NOT SURE

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20. **For women:** Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date? YES NO NOT SURE

Explain: _____

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

PATIENT/PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

DENTIST SIGNATURE: _____ **DATE:** _____