Medical History Questionnaire

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Diplomates of the American Board of Periodontology

Last Name: ______________________ First Name: ______________________

Referring Dentist Name: ______________________ Date: ______________________

Do you have or have you had:

	YES	NO
Heart Disease	❑	❑
Heart Surgery	❑	❑
Rheumatic Fever	❑	❑
Heart Murmur	❑	❑
Mitral Valve Prolapse	❑	❑
Abnormal blood pressure	❑	❑
Ulcers	❑	❑
Radiation/Chemotherapy	❑	❑
Cancer	❑	❑
Tuberculosis or Lung Disease	❑	❑
Diabetes	❑	❑
Epilepsy/seizures	❑	❑
Anemia	❑	❑
Psychological or emotional Disorders	❑	❑
Asthma or Hay Fever	❑	❑
Sinus Trouble	❑	❑
Cough (persistent)	❑	❑
Hepatitis or Jaundice	❑	❑
Arthritis	❑	❑
Stroke	❑	❑
Bleeding problems	❑	❑
Kidney disease	❑	❑
Do you smoke?	❑	❑
How many cigarettes/day? ______		

Have you ever had an allergic reaction to:

	YES	NO
Sulfa	❑	❑
Latex	❑	❑
Codeine/narcotics	❑	❑
Penicillin	❑	❑
Aspirin	❑	❑
Anesthetics, i.e. novocaine or epinephrine	❑	❑
Other medications or drugs	❑	❑
Name(s)		

Have you ever had:

	YES	NO
AIDS or tested HIV positive	❑	❑
Artificial heart valve	❑	❑
Cardiac pacemaker	❑	❑
Vascular grafts	❑	❑
Artificial hip or other joint	❑	❑
Herpes	❑	❑
Alcoholism/drug dependency	❑	❑
Surgery	❑	❑

Are you subject to:

	YES	NO
Fainting	❑	❑
Headache	❑	❑
Dizziness	❑	❑

	YES	NO
Are you pregnant or lactating?	❑	❑
Have you been under the care of a physician in the last two years?	❑	❑

If yes, please explain: ______________________

____

Please list any medications you are now taking: ______________________

Name of physician: ______________________ Phone: ______________________

	YES	NO
Is there anything you would like to discuss with the doctor privately?	❑	❑
Have you ever taken diet pills?	❑	❑
Do you have any other condition or disease not listed here?	❑	❑
Do you need to take antibiotics before dental appointments?	❑	❑

Doctor's Comments

______________________ ______________________

Signature of Patient or Responsible Party Date Doctor's Signature Date

Patient Information

Date ______________________

Name ______________________

Street Address ______________________ City ____________ Zip ____________

Home # ____________ Work # ____________ Cell Phone # ____________ Pager # ____________

Date of Birth ____________ Age(yrs) ____________ SS# ____________

Employer ______________________

Spouses Name ______________________ Employer ______________________

Who to Contact in an Emergency:

Name ______________________ Phone# ______________________

Referred to our office by ______________________

Person Responsible for Bill

Name ______________________ Relationship ______________________

Address ______________________

SS# ______________________ Employer ______________________

Dental Insurance Information

Insured Person's Full Name ______________________

Address ______________________ Work # ____________

Date of Birth ______________________ SS# ______________________

Relationship to Patient ______________________

Employer's Name ______________________ Employer Address ______________________

Insurance Company Name ______________________

Group or Union Name ______________________

Group or Local Number ______________________

Second Dental Insurance Information

Insured Person's Full Name ______________________

Address ______________________ Work # ____________

Date of Birth ______________________ SS# ______________________

Relationship to Patient ______________________

Employer's Name ______________________ Employer Address ______________________

Insurance Company Name ______________________

Group or Union Name ______________________

Group or Local Number ______________________

I authorize release of information to my dental insurance.

I authorize payment of dental benefits to the dentist.

Signature ______________________