MEDICAL HISTORY QUESTIONNAIRE

Rosslyn Family Dental

NAME: _____________________________________ **DATE:** ____________________________________

ADDRESS: ____

HOME PHONE: ___________________________ **CELLPHONE:** __________________________________

EMAIL (we send reminder confirmations via email) ____

WHO REFERRED YOU TO OUR OFFICE? ____

FAMILY DOCTOR: _______________________________ **PHONE#:** ______________________________

EMERGENCY CONTACT: ______________________________**PHONE#:** ___________________________

RELATIONSHIP TO PATIENT:____

ALL INFORMATION IS PRIVATE, AND PROTECTED BY DOCTOR-PATIENT CONFIDENTIALITY. PLEASE FILL IN THE ENTIRE FORM AND CIRCLE THE CORRECT ANSWERS.

1. **ARE YOU CURRENTLY BEING TREATED BY A DOCTOR FOR ANY MEDICAL CONDITION OR HAVE YOU BEEN TREATED WITHIN THE PAST YEAR? YES / NO**
   IF YES PLEASE EXPLAIN:
   ____
   ____
2. **WHEN WAS YOUR LAST MEDICAL CHECK UP?** ____
3. **HAVE THERE BEEN ANY CHANGES IN YOUR HEALTH OVER THE PAST YEAR?**
   ____
4. **ARE YOU TAKING ANY NEW MEDICATIONS, NON-PRESCRIPTION DRUGS OR HERBAL SUPPLEMENTS OF ANY KIND? IF YES, PLEASE LIST THEM.**
   ____
   ____
5. **DO YOU HAVE ANY ALLERGIES? IF YES, PLEASE LIST THEM:**
   ____
   ____
6. **HAVE YOU EVER HAD A REACTION TO ANY MEDICINES OR INJECTIONS? YES / NO**

7. **DO YOU HAVE ASTHMA? YES / NO**
8. **DO YOU HAVE OR HAVE YOU EVER HAD HEART OR BLOOD PRESSURE PROBLEMS? YES / NO**
9. **HAVE YOU EVER HAD REPLACEMENT OR REPAIR OF A HEART VALVE, AN INFECTION OF THE HEART, A HEART CONDITION FROM BIRTH OR A HEART TRANSPLANT? YES / NO**
10. **DO YOU HAVE ANY PROSTHETIC OR ARTIFICIAL JOINTS? YES / NO**
11. **DO YOU HAVE ANY CONDITIONS THAT COULD AFFECT YOUR IMMUNE SYSTEM?** (Leukemia, chemotherapy, radiotherapy, AIDS, HIV, or any other STDs) **YES / NO**
    PLEASE EXPLAIN: ____
12. **HAVE YOU EVER HAD HEPATITIS, JAUNDICE, OR LIVER DISEASE? YES / NO**
13. **DO YOU HAVE ANY BLEEDING DISORDERS? YES / NO**
14. **HAVE YOU EVER BEEN HOSPITALIZED FOR ANY ILLNESS OR OPERATION? YES / NO**
    IF YES PLEASE EXPLAIN ____
15. **DO YOU OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?**

*Chest pain, angina ____	*Kidney Disease ___
*Stroke, TIA ___	*Rheumatic fever ___
*Pacemaker ___	*Tuberculosis ___
*Stomach Ulcers ___	*Steroid therapy ___
*Seizures ___	* Thyroid Disease __
*Cancer __	*Heart attack ___
*Mitral valve prolapses __	*Heart murmur ___
*Arthritis ___	*Lung Disease ___
*Diabetes ___	*Osteoporosis medications ___

16. **ARE THERE ANY CONDITIONS / DISEASES NOT LISTED ABOVE THAT YOU HAVE OR HAVE HAD?**
    ____
17. **DO ANY DISEASES OR MEDICAL CONDITIONS RUN IN YOUR FAMILY?**
    ____
18. **DO YOU SMOKE OR CHEW TOBACCO PRODUCTS? YES / NO**
19. **ARE YOU NERVOUS DURING DENTAL PROCEDURES? YES / NO**
20. **ARE YOU CURRENTLY BREASTFEEDING OR PREGNANT? YES / NO**

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS CORRECT.

PATIENT/GUARDIAN SIGNATURE: ____

DATE: ______________________________