MEDICAL HISTORY QUESTIONNAIRE

MEDICAL ALERT (Office Use Only) ____

Name: ____ Date: _______________________

Address (Home):____ City: __________________________________

Prov/State: _________________ Postal Code/ Zip: ___________________ Date of Birth: ____________________________

Phone Home: _______________________Cell: __________________________Work:_____________________________

Email: ____ Referred by: ____________________________________

Employer: ______________________________________ Occupation: _____________________________________

Name of Family Doctor: ___________________________ Phone or Address of MD: __________________________________

Name of Medical Specialist: _______________________________ Area of Specialty: ____________________________

In Case of Emergency Notify: _________________________ Phone: _________________Relationship: _________________

Dental Insurance: Yes / No If Yes: Name of Insurance Company: ____

Name of the Person Who is the Subscriber of Insurance: ____

Subscriber's Date of Birth: ____________________Group/Plan No.: ______________Certificate/ID No.: _________________

The following information is required to enable us to provide you with the best possible dental care. All information is strictly confidential. Please try to answer every question and feel free to ask the dentist or staff for help in completing this form.

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/MAYBE

   ____

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

   ____

4. Are you taking any medications, non-prescription or herbal supplements of any kind? If yes, please list.

   ______________________ ______________________ ______________________
   ______________________ ______________________ ______________________
   ______________________ ______________________ ______________________

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

   ☐ YES ☐ NO ☐ NOT SURE/MAYBE

   a) Medications ____
   b) Latex/rubber products____
   c) Other (e.g. hay fever ,foods)____

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 or have you ever had asthma? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

____

8. Do you have or have you ever had any heart or blood pressures problems? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

____

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/MAYBE

____

10. Do have a prosthetic or artificial joint? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

____

11. Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiation treatment, chemotherapy? ☐ YES ☐ NO

____

If applicable, what was the date of your last chemo treatment ______________________________

If applicable, what was the date of your last radiation treatment ______________________________

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

____

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

____

14. Have you ever been hospitalized for any illnesses or operations? If yes, please explain. ☐ YES ☐ NO

____

15. Do you have or have you ever had any of the following. Please check all that apply.

☐chest pain, angina ☐rheumatic fever ☐pacemaker ☐steroid therapy ☐seizures (epilepsy) ☐stomach ulcers

☐heart attack ☐heart murmur ☐lung disease ☐diabetes ☐kidney disease ☐thyroid disease

☐stroke ☐cancer ☐tuberculosis ☐arthritis ☐shortness of breath

☐mitral valve prolapse ☐drug/alcohol dependency ☐osteoporosis medications ☐malignant hyperthermia

____

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

☐ YES ☐ NO ☐ NOT SURE/MAYBE

____

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

☐ YES ☐ NO ☐ NOT SURE/MAYBE

____

18. Do you smoke or chew tobacco products? ☐ YES ☐ NO

____

19. Are you nervous during dental treatment? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

____

20. **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:

____

*Please bring completed form to your appointment or email to info@delvecchiodentistry.com