Alameda Dental

MEDICAL HISTORY QUESTIONNAIRE

Name _____ Age _____

Emergency Contact Name _____ Relation _____ Phone _____

Name of Physician/and their specialty? _____

Date of Most Recent Physician Visit _____ What for? _____

What is your estimate of your general health? Excellent Good Fair Poor

Have you ever had:

YES NO

- ☐ ☐ Hospitalization for illness or injury
- ☐ ☐ Allergic reaction to:
  - ___ Aspirin, ibuprofen, acetaminophen, codeine
  - ___ Penicillin
  - ___ Erythromycin
  - ___ Tetracycline
  - ___ Sulfa
  - ___ Local Anesthetic ("novocaine")
  - ___ Fluoride
  - ___ Metals (nickel, gold, silver _____)
  - ___ Latex
  - ___ Other _____
- ☐ ☐ Heart problems, or cardiac stent within last 6 mos
- ☐ ☐ History of infective endocarditis
- ☐ ☐ Artificial heart valve, repaired heart defect (PFO)
- ☐ ☐ Pacemaker or implantable defibrillator
- ☐ ☐ Artificial prosthesis (heart valve or joints)
- ☐ ☐ Rheumatic or scarlet fever
- ☐ ☐ High or Low Blood Pressure
- ☐ ☐ Stroke (taking blood thinners)
- ☐ ☐ Anemia or other blood disorder
- ☐ ☐ Prolonged bleeding due to slight cut (INR >3.5)
- ☐ ☐ Emphysema, sarcoidosis
- ☐ ☐ Tuberculosis
- ☐ ☐ Asthma
- ☐ ☐ Breathing or Sleep Problems (i.e. snoring, sinus)
- ☐ ☐ Kidney Disease
- ☐ ☐ Liver Condition
- ☐ ☐ Thyroid, parathyroid, or calcium deficiency
- ☐ ☐ Hormone Deficiency
- ☐ ☐ High Cholesterol or taking statin Drugs
- ☐ ☐ Diabetes (HbA1c = _____)
- ☐ ☐ Stomach or Duodenal Ulcer
- ☐ ☐ Digestive Disorders (ie. Gastric reflux)

YES NO

- ☐ ☐ Osteoporosis/osteopenia (i.e. taking bisphosphonates)
- ☐ ☐ Arthritis
- ☐ ☐ Glaucoma
- ☐ ☐ Head or Neck Injury
- ☐ ☐ Epilepsy, convulsions (seizures)
- ☐ ☐ Neurologic Problem (attn. deficit disorder)
- ☐ ☐ Viral Infections and cold sores
- ☐ ☐ Any lumps or swelling in the mouth
- ☐ ☐ Hives, skin rash, hay fever
- ☐ ☐ Venereal Disease
- ☐ ☐ Hepatitis (type_____)
- ☐ ☐ HIV/AIDS
- ☐ ☐ Tumor, abnormal growth
- ☐ ☐ Radiation Therapy
- ☐ ☐ Chemotheraphy
- ☐ ☐ Psychiatric treatment
- ☐ ☐ Antidepressant Medication
- ☐ ☐ Alcohol/ street drug use

Are You:

- ☐ ☐ Presently being treated for any illness
- ☐ ☐ Aware of a change in your health (i.e. fever, new cough)
- ☐ ☐ Taking medication for weight mgmt. (i.e. fen-phen)
- ☐ ☐ Often exhausted or fatigued
- ☐ ☐ Experiencing frequent headaches
- ☐ ☐ A current or past smoker and/or smokeless tobacco user
- ☐ ☐ Often unhappy or depressed
- ☐ ☐ FEMALE- taking birth control pills
- ☐ ☐ FEMALE- pregnant
- ☐ ☐ MALE- prostate condition

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment. (ie botox injection) _____

List all Medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose

Please use an additional sheet if needed, or bring a printed list of medicines
Please advise us in the future of any change in your Health History

Patient's Signature _____ Date _____

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