MEDICAL QUESTIONNAIRE

The following information is required to enable us to provide you with best possible dental care.
All information is strictly private, and is protected be doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire 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 you 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/MAYBE

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list. ☐ YES ☐ NO ☐ NOT SURE/MAYBE

5. Do you have any allergies? If you answered yes, please list using the categories below:
   a. Medications ☐ YES ☐ NO ☐ NOT SURE/MAYBE
   b. Latex/rubber products
   c. Other. E.g. Hay fever, foods

6. Have you ever had a peculiar or adverse reaction to any medications or injection? 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 have or have you ever had any heart or blood pressure problems?
   ☐ YES ☐ NO ☐ NOT SURE/MAYBE

9. Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever?
   ☐ YES ☐ NO ☐ NOT SURE/MAYBE

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

11. Have you ever been advised by your doctor to take antibiotics before dental treatment?
    ☐ YES ☐ NO ☐ NOT SURE/MAYBE

12. 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/MAYBE

13. Have you ever had hepatitis, jaundice, or liver disease?

☐ YES ☐ NO ☐ NOT SURE/MAYBE

14. Do you have a bleeding problem or bleeding disorder?

☐ YES ☐ NO ☐ NOT SURE/MAYBE

15. Have you ever been hospitalized for any illness or operations? If yes, please explain.

☐ YES ☐ NO ☐ NOT SURE/MAYBE

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16. Do you have or have you ever had any of the following? Please check.

☐ Chest pain, angina	☐ Prosthetic heart valve	☐ Pacemaker	☐ Steroid Therapy
☐ Diet Pill Therapy	☐ Heart Attack	☐ Lung Disease	☐ Diabetes
☐ Stroke	☐ Shortness of Breath	☐ Drug/Alcohol Dependency	
☐ Seizures (epilepsy)	☐ Kidney Disease	☐ Cancer	☐ Arthritis
☐ Stomach Ulcers	☐ Tuberculosis	☐ Thyroid Disease	

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

☐ YES ☐ NO ☐ NOT SURE/MAYBE

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18. Are there any disease or medical problems that run in your family? (E.g. diabetes, cancer, or heart disease) ☐ YES ☐ NO ☐ NOT SURE/MAYBE

19. Do you smoke or chew tobacco products?

☐ YES ☐ NO ☐ NOT SURE/MAYBE

20. Are you nervous during dental treatment?

☐ YES ☐ NO ☐ NOT SURE/MAYBE

21. For Women Only: Are you breast-feeding or pregnant? If pregnant, what is the expected delivery date?

☐ YES ☐ NO ☐ NOT SURE/MAYBE

22. Have you ever been told that you, or anyone with whom you have household contact with, have or have had “MRSA” or “VRE” (either “colonized” or “infected”) or a “superbug”?

☐ YES ☐ NO ☐ NOT SURE/MAYBE

23. Do you currently have an unexplained fever or cough or do you generally feel unwell?
    a. Do you have a pain in your chest? ☐YES ☐NO ☐NOT SURE/MAYBE
    b. Are you coughing up blood or sputum? ☐YES ☐NO ☐NOT SURE/MAYBE
    c. Do you have weakness or fatigue, unexplained weight loss, and/or loss of appetite? ☐YES ☐NO ☐NOT SURE/MAYBE
    d. Do you have chills with your fever? ☐YES ☐NO ☐NOT SURE/MAYBE
    e. Do you have night sweats? ☐YES ☐NO ☐NOT SURE/MAYBE
    f. Do you currently have any of the following Symptoms? (Stuffy nose, Sore throat, Muscle/ Body Aches, Vomiting) ☐YES ☐NO ☐NOT SURE/MAYBE

24. Have you recently been exposed to or do you have a history of TB or influenza (the "flu") disease? If so, please advise of the circumstances.
    ☐ YES ☐ NO ☐ NOT SURE/MAYBE

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25. Are you being treated for current or recent diarrhea or do you have unexplained diarrhea?
    ☐ YES ☐ NO ☐ NOT SURE/MAYBE

26. Do you have any new uncomfortable symptoms associated with urination?(e.g. pain, blood in urine)
    ☐ YES ☐ NO ☐ NOT SURE/MAYBE

27. Are you being treated for, or do you have a new rash, lesion, break in the skin or pimple-like lesion that has not been diagnosed?
    ☐ YES ☐ NO ☐ NOT SURE/MAYBE

28. Have you ever been diagnosed with CJD (sporadic, familial or latrogenic), Gerstmann-Straussler-Scheinker syndrome (GSS), fatal familial insomnia (FFI) or other prion disease?
    ☐ YES ☐ NO ☐ NOT SURE/MAYBE

29. Do you have any undiagnosed, unusual progressive neurological disease that includes the following:
    a. Dementia or a loss of cognitive ability? ☐YES ☐NO ☐NOT SURE/MAYBE
    b. Myoclonus or an involuntary twitching of a muscle or group of muscles? ☐YES ☐NO ☐NOT SURE/MAYBE
    c. Ataxia or a lack of coordination Of muscle group ☐YES ☐NO ☐NOT SURE/MAYBE

30. Have you had many treatments with antibiotics over the course of your life? If so, please describe.
    ☐ YES ☐ NO ☐ NOT SURE/MAYBE

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31. Have you ever had chemotherapy or been told that you are immuno-compromised?
    ☐ YES ☐ NO ☐ NOT SURE/MAYBE

32. Have you had any recent exposure to communicable infectious disease? (e.g. measles, chicken pox or tuberculosis)

 YES NO NOT SURE/MAYBE

33. Do you have a history of joint prosthesis procedures in the last two years?

 YES NO NOT SURE/MAYBE

34. Have you recently travelled to areas where endemic diseases are present?

 YES NO NOT SURE/MAYBE

35. Immunization history?

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

Patient/Parent/Guardian Signature_____ Date_____

Dentist Signature_____ Date_____