MEDICAL-DENTAL QUESTIONNAIRE

Name	Sex	Birth Date	Race
Address (Street, City, State, Zip Code)		Marital Status	
Home Phone	Office Phone	Occupation	

Highest Grade Attained in School
1 2 3 4 5 6 7 8 9 10 11 12

College
1 2 3 4

IN CASE OF EMERGENCY, PLEASE NOTIFY

Name		Relation
Address		Phone
Medical Doctor's Name	Address	Phone
Last Physical Examination was on (Date)	Hospital Number	

Are you being treated by a Medical Doctor now? 1. ❑ Yes ❑ No	If Yes, for what reason?
Are you taking any medicine at the present time? 2. ❑ Yes ❑ No	What?
Are you sensitive or allergic to any medicine? 3. ❑ Yes ❑ No	If Yes, what?
Have you ever been hospitalized or had any surgical operations? 4. ❑ Yes ❑ No	If Yes, list reasons and dates.
Have your ever had a blood transfusion? 5. ❑ Yes ❑ No	If Yes, give reason.

6. Have You Had:

A.	ASTHMA	Yes	No
B.	HAYFEVER	Yes	No
C.	TUBERCULOSIS	Yes	No
D.	RHEUMATIC FEVER	Yes	No
E.	SCARLET FEVER	Yes	No
F.	HEART MURMUR	Yes	No
G.	HEART DISEASE	Yes	No
H.	ANGINA PECTORIS	Yes	No
I.	STROKE	Yes	No
J.	HIGH BLOOD PRESSURE	Yes	No
K.	LOW BLOOD PRESSURE	Yes	No
L.	ANEMIA	Yes	No
M.	ALLERGIES OR HIVES	Yes	No
N.	ULCERS (Stomach or Intestinal)	Yes	No
O.	ARTHRITIS	Yes	No
P.	RHEUMATISM	Yes	No
Q.	VENEREAL DISEASE (Syphilis or Gonorrhea)	Yes	No
R.	KIDNEY OR BLADDER DISEASE	Yes	No
S.	HEPATITIS	Yes	No
T.	GALL BLADDER DISEASE	Yes	No
U.	DIABETES (Sugar Disease)	Yes	No
V.	NERVOUSNESS	Yes	No
W.	EPILEPSY OR SEIZURES	Yes	No
X.	FAINTING OR DIZZY SPELLS	Yes	No
Y	GLAUCOMA	Yes	No
Z.	PACEMAKER	Yes	No
AA.	THYROID DISEASE (or Goiter)	Yes	No
BB.	X-RAY OR COBALT TREATMENT	Yes	No
CC.	PSYCHIATRIC TREATMENT	Yes	No
DD.	CHEMOTHERAPY (Cancer, Leukemia)	Yes	No

(OVER)

DENTAL HISTORY

7. Have you had any serious trouble associated with any previous dental treatment .... Yes No

   If yes, explain: ______________________________

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8. Do you bleed excessively, after tooth extraction? .... Yes No
9. Have you recently had dental x-rays? If yes, when: ______________ Yes No
10. Have you had undesirable reactions to local or general anesthetics? (For example, Novocaine or Gas) .... Yes No
11. Do you clench or grind your teeth? .... Yes No
12. Have you ever had injury to your face or jaws? .... Yes No
13. Are any of your teeth sensitive to cold or sweets? .... Yes No
14. Are you dissatisfied with the appearance of your teeth? .... Yes No
15. Have you ever had excessive swelling or pain after oral surgery? .... Yes No
16. Have you ever been instructed in caring for your teeth and gums? .... Yes No
17. Do you have any present dental problems? Explain: ______________ Yes No

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Name of Person who Referred you: ______________________________

Social Security # ______________ Driver's License# ______________

To the best of my knowledge all of the above answers are true and correct.
If I have any change in my health, I will inform my Dentist at the next appointment.

PLEASE READ THE FOLLOWING CAREFULLY AND SIGN WHERE INDICATED:

APPOINTMENT POLICY

Please be aware that by making an appointment, you are stating that you will be present for that appointment, just as we are stating that we will be here to serve you. We consider an appointment written in our schedule as a bond of trust and therefore should not be broken. Your signature below indicates that we will have mutual respect for each other's time

______________________________ ______________

Patient (or guardian) Date