MEDICAL QUESTIONAIRE

Name: ____ Date of Birth: ____________________

Occupation: ____ Referred by: ____________________

Please describe main reason for visit: ____

Please list medications which you may be allergic: ____

Please list all medications you are currently taking. Include *over-the-counter medicines,* ***supplements*** and those used only occasionally.

Medication	Dose	Frequency

How much alcohol do you consume in a week?

How much tobacco do you consume in a week?

Have you been diagnosed with, treated for, or received any of the following?

	Please Circle	
Heart Disease	yes	no
High Blood Pressure	yes	no
Angina or Heart Attack	yes	no
Heart Rhythm Disturbance	yes	no
Pacemaker	yes	no
Heart Murmur	yes	no
If yes, do you take antibiotics prior to dental procedures	yes	no
Breathing Difficulties	yes	no
Bleeding disorder or tendency	yes	no
Kidney disease	yes	no
Diabetes	yes	no
Glaucoma	yes	no
Liver disease	yes	no
Intestinal Colitis	yes	no
Hepatitis or yellow jaundice	yes	no

	Please Circle	
Blood transfusion	yes	no
Aids or HIV infection	yes	no
Cold sores or fever blisters	yes	no
Excessive scarring or keloids	yes	no
Problems with healing	yes	no
Dizziness or fainting	yes	no
Stroke	yes	no
Seizures or epilepsy	yes	no
Psychiatric illness or Emotional problems	yes	no
X-ray exposure or Radiation treatments	yes	no
PUBA or UVA light treatments	yes	no
Skin cancer	yes	no

If yes,

Type	Location	Year

Please list any other illness below:

Please list any previous hospitalization or surgery with reason and date:

Signature: ____ Date: _________________

____

Md. Review