

MEDICAL QUESTIONNAIRE

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			Please Circle	
Heart Disease	yes	no	Blood Transfusion	yes	no
High Blood Pressure	yes	no	Aids or HIV Infection	yes	no
Angina or Heart Attack	yes	no	Cold Sores or Fever Blisters	yes	no
Heart Rhythm Disturbance	yes	no	Excessive Scarring or Keloids	yes	no
Pacemaker	yes	no	Problems with Healing	yes	no
Heart Murmur	yes	no	Dizziness or Fainting	yes	no
If yes, do you take antibiotics prior to dental procedures	yes	no	Stroke	yes	no
Breathing Difficulties	yes	no	Seizures or Epilepsy	yes	no
Bleeding Disorder or Tendency	yes	no	Psychiatric Illness or Emotional Problems	yes	no
Kidney Disease	yes	no	X-ray Exposure or Radiation Treatments	yes	no
Diabetes	yes	no	PUBA or UVA Light Treatments	yes	no
Diabetes	yes	no	If yes,		
Glaucoma	yes	no	Type	Location	Year
Liver Disease	yes	no	_____	_____	_____
Intestinal Colitis	yes	no	_____	_____	_____
Hepatitis or Yellow Jaundice	yes	no	_____	_____	_____

Please list any other illness below: _____

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

