Heritage Dental™

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O. Bernardi	DDS. Cert. IV Sed.
G. Cantwell	DDS. FAGD
L. Vaupotic	DDS
R. Krause	MD
M. Angeles	MD
P. Perna	MD
S. Weinberger	DDS. Cert. Pedo. & Ortho.
G. Simon	MD

MEDICAL HISTORY

QUESTIONNAIRE

MEDICAL ALERT:

NAME: MR. /MISS /MRS. /MS. /DR.

_____

DATE OF BIRTH (DD/MM/YYYY): / /

ADDRESS (HOME):

_____

_____

PHONE: _____

ADDRESS (BUSINESS):

_____

_____

PHONE: _____

OCCUPATION: _____

WHO REFERRED YOU TO OUR OFFICE?

_____

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME: _____

RELATIONSHIP: _____

DAY-TIME PHONE: _____

NAME OF FAMILY DOCTOR: _____

PHONE OR ADDRESS: _____

_____

(1) NAME OF MEDICAL SPECIALIST: _____

AREA OF SPECIALITY: _____

PHONE OR ADDRESS: _____

INSURANCE COMPANY: _____

POLICY NUMBER: _____

CERT NUMBER: _____

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by 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 your 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:
☐ YES ☐ NO ☐ NOT SURE/ MAYBE

a) medications
b) latex/rubber products
c) other e.g. hayfever, foods

_____

_____

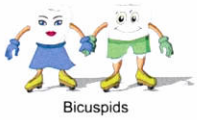
6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.

_____

_____

7. Do you have or have you ever had asthma? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

Joules the molar



Bicuspids

8. Do you 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 illnesses or operations? If yes, please explain. ☐ YES ☐ NO ☐ NOT SURE/ MAYBE

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

☐ chest pain, angina	☐ shortness of breath	☐ pacemaker	☐ steroid therapy	☐ diet pill therapy
☐ heart attack	☐ prosthetic heart valve	☐ drug/alcohol dependency	☐ seizures (epilepsy)	☐ thyroid disease
☐ stroke		☐ cancer	☐ tuberculosis	☐ kidney disease
☐ lung disease			☐ diabetes	☐ arthritis
☐ stomach ulcers				

17. Are there any conditions or diseases not listed above that you have or have had? If so, what? ☐ YES ☐ NO ☐ NOT SURE/ MAYBE

18. Are there any diseases 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

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

PATIENT/PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

DENTIST SIGNATURE: _____ **DATE:** _____

DENTIST'S NOTES: