MEDICAL HISTORY QUESTIONNAIRE

Name:_____ Date of Birth:_____

Family Physician:_____ Physician's Phone:_____

Specialist:_____ Physician's Phone:_____

CURRENT / PREVIOUS MEDICAL HISTORY

Please indicate with an (**X**) any of the following which you currently have, or have previously had:

ALLERGIES

Are you **allergic** or have you reacted adversely to any of the following?

- ❑ Local Anesthetics
- ❑ Sedatives
- ❑ Sulfa Drugs
- ❑ Latex
- ❑ Penicillin
- ❑ Aspirin
- ❑ Codeine
- ❑ Metals
- ❑ Barbiturates
- ❑ Sleeping Pills

Please list all other drug allergies:_____

HEART

- ❑ Shortness of Breath
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Heart Disease
- ❑ Chest Pains
- ❑ Heart Murmur
- ❑ Heart Attack
- ❑ Congenital Heart Lesions
- ❑ Damaged Heart Valves
- ❑ Artificial Heart Valves
- ❑ Stroke

PREMED

Have you ever been advised by a physician to take an antibiotic because you have any of the following conditions:

- ❑ Heart Murmur
- ❑ Mitral Valve Prolapse
- ❑ Rheumatic Fever
- ❑ Artificial Joint, Limb Replacement
- ❑ Other_____

BLOOD

	YES	NO
Are you currently on an ASPIRIN regimen?	❑	❑
Are you taking BLOOD THINNERS?	❑	❑
Are you ANEMIC?	❑	❑
Have you had ABNORMAL BLEEDING after extractions or surgery?	❑	❑

Do you have any BLOOD DISEASES/DISORDERS?
If yes, please explain_____

FEMALE

Are you presently using an oral contraceptive?	❑	❑
Are you pregnant?	❑	❑

SEE REVERSE SIDE

Name:_____ Date of Birth:_____

DO YOU HAVE:	YES	NO		YES	NO
Diabetes	❑	❑	Kidney/Bladder Problems	❑	❑
Hepatitis	❑	❑	Stomach Ulcers	❑	❑
Liver Disease	❑	❑	Tuberculosis	❑	❑
Epilepsy or Seizures	❑	❑	Hearing Loss	❑	❑
Asthma	❑	❑	HPV	❑	❑
Thyroid Disease	❑	❑	HIV / AIDS	❑	❑
Arthritis / Rheumatism	❑	❑	Osteoporosis	❑	❑
Cancer / Tumors	❑	❑	Sinus Trouble	❑	❑
If yes, what type?_____			Psychiatric Problems	❑	❑

	YES	NO
Have you ever had radiation to your Head/Neck (not dental x-rays)?	❑	❑
Have you ever had surgery or the removal of any tumor or growth to your head/neck?	❑	❑
Are you employed in any situation which exposes you regularly to x-rays or other Ionizing Radiation?	❑	❑
Do you have or have you had any other disease, serious illness, condition or problem not listed above that I should be aware of?	❑	❑

_____

_____

Have you been under a doctors care within the past year? ❑ ❑

If yes, please explain_____

_____

Do you smoke/chew tobacco? ❑ Yes ❑ No Drink Alcohol? ❑ Yes ❑ No Use recreational Drugs? ❑ Yes ❑ No

If yes, to what extent_____

Have you ever taken cortisone or steroids?? ❑ ❑

If yes, please explain_____

Have you had general or local anesthesia in the past? ❑ ❑

If yes, please explain_____

In case of emergency, please notify:

Name:_____ Phone: (_____)_____

Relationship: _____

CONSENT TO TREATMENT

I certify that I, undersigned, consent to the performance of any and all procedures, and the use of any and all drugs that are agreed to be necessary or advisable. I will not hold Dr. Brunetti or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

I hereby authorize photocopies of this form to be valid as the original.

DATE:_____ PATIENT'S SIGNATURE:_____

(IF MINOR, PARENT / GUARDIAN SIGNATURE)

Name:_____ Date of Birth_____

DENTAL HISTORY

	YES	NO
Are you nervous about going to the dentist?	❑	❑
Have you been under regular care by a dentist?	❑	❑
Have you ever had any bad dental experience?	❑	❑
Have you ever had any teeth extracted?	❑	❑
Do any of your teeth ache?	❑	❑
Do your gums bleed when you brush?	❑	❑
Do your gums feel tender or swollen?	❑	❑
Do you have any loose teeth?	❑	❑
Does food catch between your teeth?	❑	❑
Do you now have a sore throat or cold?	❑	❑
Does your drinking water contain fluoride?	❑	❑

What is your present dental concern? _____

CURRENT MEDICATIONS

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING, THE DOSAGE AND THE INSTRUCTIONS SO IT CAN BE NOTED IN YOUR CHART

Date	Medication	Dosage	Directions for Taking Medication
