Dr. Paul DeMan
Medical History Questionnaire

Mr./Mrs./Ms./Miss/Dr. (circle) Day/Month/Year

Name: _____ Date of Birth: ____/____/____

Address: _____ Postal Code_____

Home Phone#_____ Work Phone#_____Cell#_____

EMAIL_____ (strictly for communication with our office only)

Do you wish to have appointments confirmed by text or email? _____

Employer:_____Occupation:_____

Who or What may we thank for referring you to our office? _____

In case of Emergency, we should notify:

Name: _____

Relationship:_____Phone:_____

Name of Family Doctor:_____ Doctor's Phone # _____

The following information is required to enable us to provide you with the best possible dental care. The dental hygienist and/or the dentist will review the questions and explain any that you do not understand. Please fill in the entire form, your information will be kept in strict confidence.

1. Are you being treated for any medical conditions at the present or have you been treated in the past year? If so, why?
_____ □Yes □No

2. Has there been any change in your general health in the past year? If Yes, please explain. □Yes □No
_____

3. Are you taking ANY MEDICATIONS, non-prescription drugs or herbal supplements of any kind? □Yes □No
If Yes please list:

	DRUG NAME	CONDITION DRUG USED FOR	DOSAGE
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

4. Do you have ANY ALLERGIES? If Yes, please list using the categories below: □Yes □No
A) Medications (ex.Penicillin)_____
B) Latex/Rubber Products _____
C) Other (ex. foods, hayfever) _____

5. Have you ever had an adverse reaction to any medications or dental injections? If Yes, please explain. □Yes □No
_____

6. Do you have or have you had asthma? If Yes , do you carry any emergency medication i.e.inhaler? □Yes □No
_____

7. Do you have or have you ever had any heart or blood pressure problems? If Yes, please explain. □Yes □No
_____

8. Do you have or have you had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e.congenital heart disease) or a heart transplant? □Yes □No
Have you been told that you require premedication before dental treatment? If Yes, please explain.
_____

9. Do you have a prosthetic or artificial joint? If Yes, please explain. □Yes □No
_____

10. Do you have any conditions or therapies that could affect your immune system? e.g. Cancer, leukemia, AIDS, HIV radiotherapy, chemotherapy? If Yes, please explain. □Yes □No
_____

11. Do you have or have you ever had HEPATITIS, jaundice or liver disease? If Yes, please explain. □Yes □No
_____

12. Do you have a bleeding problem or bleeding disorder? If Yes, please explain. □Yes □No
_____

13. Have you been hospitalized for any illness or operations? If Yes, please explain. □Yes □No
_____

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

□ chest pain,angina	□rheumatic fever	□pacemaker	□steroid therapy	□seizures (epilepsy)	□osteoporosis
□ heart attack	□mitral valve prolapse	□lung disease	□kidney disease	□diabetes	medications
□ stroke		□tuberculosis	□stomach ulcers	□ thyroid disease	(e.g. Fosamax, Actonel)
□ shortness of breath	□heart murmur	□ cancer	□ arthritis	□ drug/alcohol dependency	

15. Are there any diseases or conditions not listed above that you have or have had? If Yes, please list. □Yes □No
_____

16. Are there any diseases or medical problems that run in your family? (e.g. diabetes, heart disease) □Yes □No
If Yes, please list._____

17. Do you smoke or chew tobacco products? If Yes, how often? (e.g. pack/day, 4-5 cigarettes/day) □Yes □No
_____

18. Are you nervous during dental treatment? If Yes, have you ever been prescribed oral sedation before?
_____ □Yes □No

19. **FOR WOMEN ONLY**: Are you pregnant or breastfeeding? If pregnant, when is the expected delivery date?
_____□Yes □No □ Maybe/Not Sure

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

Patient/Parent/Guardian:
Signature:_____Date:_____

Dentist Signature: _____
Notes: