

**Medical Questionnaire**

Correct answers to the following questions will allow your dentist to treat you so there **WILL NOT** be an emergency. However, if an emergency situation does arise, this information will help insure proper treatment. As before, your answers are for our records only and will be considered confidential.

Do you have or have you ever had:

- Anemia \_\_\_ Yes \_\_\_ No
- Diabetes \_\_\_ Yes \_\_\_ No
- Allergies
  - To penicillin \_\_\_ Yes \_\_\_ No
  - To local anesthetics \_\_\_ Yes \_\_\_ No
  - Other \_\_\_\_\_ \_\_\_ Yes \_\_\_ No
- Abnormal heart condition \_\_\_ Yes \_\_\_ No
- Tuberculosis \_\_\_ Yes \_\_\_ No
- Abnormal bleeding from a cut \_\_\_ Yes \_\_\_ No
- Rheumatic fever \_\_\_ Yes \_\_\_ No
- Joint replacement \_\_\_ Yes \_\_\_ No
- High Blood Pressure \_\_\_ Yes \_\_\_ No
- Hyper or Hypo Thyroidism \_\_\_ Yes \_\_\_ No
- Heart murmur/Mitral valve prolapse \_\_\_ Yes \_\_\_ No
- AIDS or HIV infection \_\_\_ Yes \_\_\_ No
- Hepatitis \_\_\_ Yes \_\_\_ No Type\_\_\_\_\_
- Migrains/Persistant Headaches \_\_\_ Yes \_\_\_ No
- Are you under the care of a physician now? \_\_\_ Yes \_\_\_ No
- Are you taking any medications? \_\_\_ Yes \_\_\_ No
- If yes, what? \_\_\_\_\_

Date of last medical examination \_\_\_\_\_

Name of Physician \_\_\_\_\_

Physician's Office Phone Number \_\_\_\_\_

Other physical conditions \_\_\_\_\_

Name and Phone Number of nearest relative \_\_\_\_\_