Patient Name_____

Medical Health Questionnaire

Has there been any change in your overall health or have you had any surgeries within the past year? YES NO
If yes, please describe_____
Medical doctor's name:_____ Clinic's name:_____
Phone:_____ Date of last physical exam:_____

Please use an "x" to mark your answers if you have or have had any of the following conditions?

Cardiac Health

- ▢ Chest pain
- ▢ Pacemaker/implanted defibrillator
- ▢ Artificial heart valve/Damaged heart valve
- ▢ Heart murmur
- ▢ Previous infective endocarditis
- ▢ Rheumatic heart disease
- ▢ Congenital Heart Disease
- ▢ Arteriosclerosis
- ▢ Coronary artery disease
- ▢ Congestive heart failure
- ▢ Heart attack (Date_____)
- ▢ Heart surgery (Reason_____ Date_____)
- ▢ Heart rhythm disorder
  If yes, what kind of rhythm disorder?_____
- ▢ Stroke (Date_____)

Circulatory Health

- ▢ High blood pressure
- ▢ Anemia
- ▢ Blood transfusion
- ▢ Hemophilia
- ▢ Peripheral Artery Disease
- ▢ Other bleeding disorder:_____

Brain/Neurological Health

- ▢ Anxiety
- ▢ Depression
- ▢ Epilepsy or seizure disorder
- ▢ Post-traumatic stress disorder
- ▢ Traumatic brain injury or concussion
- ▢ Developmental delay
- ▢ Autism
- ▢ Sensory disorder
- ▢ Alzheimer's disease
- ▢ Memory loss
- ▢ Parkinson's disease
- ▢ Other mental health or neurologic disorder: _____
- ▢ Are you under the care of a mental health professional such as a therapist, counselor, psychiatrist or psychologist?

Is there anything in your past, such as previous trauma, that would be helpful for us to know to make your dental visits more comfortable? If so, please explain:_____
_____

- ▢ History of addiction? If yes to what?_____

Cancer or Tumor

Type:_____
Date of Diagnosis:_____
Chemotherapy:_____
Radiation:_____
Are you currently in remission or cancer free?_____

Respiratory Health

- ▢ Shortness of breath
- ▢ Asthma
- ▢ COPD
- ▢ Emphysema
- ▢ Chronic Bronchitis
- ▢ Sinus trouble
- ▢ Tuberculosis
- ▢ Sleep Apnea If yes, do you use CPAP?

Digestive Health

- ▢ Celiac disease
- ▢ Crohn's disease
- ▢ Irritable bowel disease
- ▢ Constipation
- ▢ Diarrhea
- ▢ GERD/Heartburn
- ▢ Stomach ulcers
- ▢ Other Gastrointestinal disorder:_____

Autoimmune Disease

- ▢ Rheumatoid Arthritis
- ▢ Sjogren's Syndrome
- ▢ Lupus
- ▢ Other:_____

Vision and Hearing Health

- ▢ Glaucoma
- ▢ Blind/impaired vision
- ▢ Deaf/impaired hearing
  If yes, do you wear hearing aids?
- ▢ Cochlear implant
- ▢ Other:_____

Other

- ▢ Migraine
- ▢ Back or neck pain
- ▢ Arthritis
- ▢ Vertigo/dizziness
- ▢ Fainting spells
- ▢ Diabetes (Type I or II) Most recent A1C?_____ ▢ Chronic pain
- ▢ Eating disorder
  If yes, what disorder?_____
- ▢ Frequent infections Type of infection?_____
- ▢ Hepatitis, jaundice or liver disease
  If yes, what type?_____
- ▢ Kidney disorder
- ▢ Malnutrition
- ▢ HIV/AIDS
- ▢ Osteoporosis
- ▢ Immune deficiency/immunocompromised
- ▢ Sexually transmitted disease
  If yes, which?_____
- ▢ Thyroid disorder: Hyperthryoid, Hypothyroid or Graves Disease
- ▢ Other endocrine disorder
  If yes, which one?_____
- ▢ Organ or bone marrow/stem cell transplant?
  If yes, what kind of transplant?_____
- ▢ Joint replacement
  Date of surgery_____
  Which joint?_____
  Does your surgeon require you to take antibiotic prophylaxis for dental treatment?
  If so, for how long do you need to take it per your physician?_____
- ▢ Other conditions, diseases or problems not noted above:_____

MEDICATIONS AND OTHER PRODUCTS/SUBSTANCES

Are you taking any of the following medications:

Blood thinners (such as Coumadin, Warfarin, rivaroxaban (Xarelto), dabigatran (Pradaxa), clopidogrel (Plavix), heparin or aspirin?
YES NO If yes, what medication?_____

Medication to treat **osteoporosis or Paget's Disease** (such as alendronate (Fosamax), risedronate (Actonel), ibandronate(Boniva), zoledronate (Reclast), and denosumab (Prolia)?
YES NO If yes, what medication?_____

IV medication/bisphosphonate to treat bone pain, hypercalcemia or skeletal complications resulting from Paget's Disease, Multiple Myeloma, or metastatic cancer such as denosumab (Xgeva), pamidronate (Aredia), or zoledronate (Zometa)?
YES NO If yes, what medication?_____ How many years have you been taking it?_____

Did you take oral bisphosphonates or receive infusions of bisphosphonates or any of the above mentioned medications for bone health at any time in the past? YES NO

Do you use any form of tobacco or nicotine products? YES NO
What kind?_____

Do you use vaping products? YES NO

How many alcoholic beverages do you have per week?_____

Do you use controlled substances (drugs) including marijuana for either medicinal or recreational use? YES NO
If yes, what substances?_____
Frequency of use?_____

What medications are you currently taking? Please include over the counter medicines, vitamins, herbs and supplements.

_____

_____

ALLERGIES

- ▢ Aspirin
- ▢ Barbiturates, sedatives, or sleeping pills
- ▢ Hay fever/seasonal allergies
- ▢ Latex (rubber)
- ▢ Metals (nickel)
- ▢ Milk
- ▢ Sulfa drugs
- ▢ Codeine or other narcotics
- ▢ Iodine
- ▢ Local anesthetics (Novocaine)
- ▢ Penicillin or other antibiotics
- ▢ Other_____

WOMEN ONLY:	**Yes**	**No**
Are you taking birth control pills?	▢	▢
Are you pregnant?	▢	▢
If yes, what is your due date?_____		
Are you nursing?	▢	▢
Have you reached menopause?	▢	▢
If yes, are you having symptoms?	▢	▢

Patient Name:_____

SLEEP APNEA SCREENING

Has anyone ever told you that you snore?.....YES NO
Do you breathe through your nose or your mouth?.....Nose or Mouth
Has a bed partner ever told you that you stop breathing at night or gasp for air while you are sleeping?.....YES NO
Do you have GERD/heartburn?.....YES NO
Do you sleep on your back or on your side?.....Back or Side
Do you feel tired during the day or fall asleep during daily tasks?……..….YES NO
Have you ever had a sleep study?.....YES NO
If yes, what was the result?_____

_____ _____
Patient signature/legally authorized representative and relationship Date

_____ _____
Printed name if signed on behalf of the patient Date

_____ _____
Doctor signature Date

_____ _____
Hygienist signature Date