MEDICAL HISTORY QUESTIONNAIRE

CHANGES/UPDATES ☐

Patient Name_____ Age_____ **Date of Assessment**_____
DOB:_____

Have you been under Dr.'s care within the last 5 years? YES/NO
(If yes, please list Dr. (s) names, related visit, and dates accordingly)

DR/Reason/ Date Last Seen/Phone Number

_____
_____
_____
_____

Have you been hospitalized or had any Surgeries? (If yes, please explain) YES/NO

_____
_____
_____

Are you currently taking any medications? **Both Prescribed or OTC, including supplements and vitamins** YES/NO
Have you taken steroids in the past year? YES/NO
Do you take the following drugs: Viagra, Cialis, Levitra, Revatio Time of last Dose:_____ YES/NO

LIST MEDICATIONS BELOW, REASON FOR TAKING and time of day:

_____-_____ - _____ _____-_____ -_____
_____-_____ - _____ _____-_____ -_____
_____-_____ - _____ _____-_____ - _____
_____-_____ - _____ _____-_____ - _____
_____-_____ - _____ _____-_____ - _____
_____-_____ - _____ _____-_____ - _____

- Is there a chance that you may be pregnant? YES/NO
- Are you breastfeeding? YES/NO

Do you have any food/substance allergies or are you allergic to any medications, including the following? YES/NO

- Latex Reaction:
- Penicillin Rash Hives Nausea Anaphylaxis Itchy
- Novocaine
- Aspirin
- Other: _____

Do you take Blood Thinners (Aspirin, Baby Aspirin, Nsaids, Plavix, Coumadin)? YES/NO
If yes, please specify:_____ PCP Patient

Do you suffer from any medical conditions that affect consciousness, such as the conditions list below? YES/NO

- Epilepsy
- Seizures
- Nervous Disorder
- Dizziness/Fainting
- Other:_____

Do you have Glaucoma? YES/NO

Do you have Hepatitis (B)? YES/NO
Do you have Hepatitis (C)? YES/NO
Do you have HIV/AIDS? YES/NO

Do you have or ever been diagnosed with Kidney Disease? YES/NO

Do you have or ever been diagnosed with Cancer? YES/NO
If yes, are you going through Chemotherapy?

Do you have any of the following?
Rheumatic Fever YES/NO
Artificial Joint(s) YES/NO
If Yes, Premed required? _____

Are you or have you ever been under Psychiatric Treatment? YES/NO

Do you use alcohol? YES/NO
How frequently? _____How many drinks per sitting?_____

Do you currently smoke or use tobacco products? YES/NO
How many a day? _____

Did you use to smoke or use tobacco products and quit? YES/NO
How long ago? _____

Do you use recreational drugs? (Remind Pt: Do not use for 48 hours before) YES/NO
If so, have you used within the last 48 hours? YES/NO
If yes, please specify:_____

Are you recovery from any drug? YES/NO
If yes, please specify:_____

Do you have any history of liver problems? YES/NO
If yes, please explain: _____

Are you Anemic? Or have you been in the past? YES/NO
Do you have any clotting/bleeding disorders? YES/NO

Are you a Diabetic? YES/NO
If yes, Please circle one: TYPE I TYPE II
If yes, Please circle one: Insulin Dependent Non-Insulin Dependent
What Medication do you take for your diabetes? _____
What is your daily glucose range?_____

Do you have any respiratory conditions such as the ones listed below? YES/NO

- **Asthma** - Have you been hospitalized in the past year for your asthma? YES/NO
  Explain/Last Attack: _____
- Emphysema
- Tuberculosis
- Sleep Apnea
- **COPD** – Have you been hospitalized in the past year for your COPD? YES/NO
  Explain/CPAP:_____
- OTHER _____

Have you ever been sedated here before? YES/NO

Have you or any family member ever experienced any anesthesia related problems? YES/NO
If yes, please explain: _____

Nausea Hard to Wake Hard to Sedate Scared of Needles

Do you have heart disease or any heart conditions? YES/NO
If yes, explain_____

Do you have any of the following? (Premed)

Heart Murmur	YES/NO
Mitral Valve Prolapse	YES/NO
Artificial Heart Valve	YES/NO
Heart Surgeries/Stents	YES/NO

Do any family member have heart disease or any heart conditions? YES/NO
If yes, who and explain_____

Do you have any Medical Condition or concern that is not mentioned above which you would like for us to know? YES/NO
If yes, please explain:_____

Do you have any religious or ethical concerns regarding your dental care involving intravenous conscious sedation? YES/NO

I, _____ verify that the above information is correct.
Print Name

Patient Signature Date