MEDICAL HEALTH QUESTIONNAIRE

Name_____ Age_____ Height_____ Weight_____

Please describe your general health: ☐excellent ☐good ☐fair ☐poor
Please list any medicines or drugs you are taking:_____

_____

Please list any medicines or drugs to which you are allergic:_____

_____

Have you been a patient in the hospital during the past 2 years?	☐ yes	☐ no
Have you been under the care of a doctor during the past 2 years?	☐ yes	☐ no
Does aspirin or ibuprofen irritate your stomach?	☐ yes	☐ no
Have you ever had an adverse reaction to any drug, anesthetic, or sedative?	☐ yes	☐ no
Have you ever had excessive bleeding that required special treatment?	☐ yes	☐ no
Have you ever been diagnosed with any immunodeficiency disorder?	☐ yes	☐ no
Do you wear contacts?	☐ yes	☐ no
Is there a history of diabetes in your family?	☐ yes	☐ no
Are you required to restrict your activity or work in any way due to your health?	☐ yes	☐ no
Are you on a special or restricted diet of any kind?	☐ yes	☐ no
Do you have any history of any kind of substance abuse?	☐ yes	☐ no
Do you use tobacco? If so, how much? _____ per day	☐ yes	☐ no
Do you vape? If so, how much? _____ per day	☐ yes	☐ no
Do you use alcohol? If so, how much? _____ per day	☐ yes	☐ no
Have you ever received IV drugs for bone cancer (i.e. Pamidronate, Aredia, Zoledronate/Zometa)?	☐ yes	☐ no
Do you take, or have you taken, drugs for osteoporosis (i.e. Fosamax, Actonel, Zometa, Boniva, Reclast, Xgeva, Alendronate, Risedronate, Denosumab, Pamidronate, Prolia)?	☐ yes	☐ no

Check any of the following which you may have had:

☐ Heart trouble	☐ High Blood Pressure	☐ Persistent Cough
☐ Congenital Heart Lesion*	☐ Low Blood Pressure	☐ Sinus Trouble
☐ Heart Murmur*	☐ Glaucoma	☐ Tuberculosis
☐ Mitro Valve Prolapse*	☐ Diabetes	☐ Asthma
☐ Heart Surgery	☐ Hepatitis or Jaundice	☐ Epilepsy
☐ Rheumatic Fever*	☐ Ulcers	☐ Arthritis
☐ Cardiac Pacemaker	☐ Kidney Disease*	☐ Stroke
☐ Heart Valve Prosthesis	☐ Psychiatric Care	☐ Joint Replacement*

*Has a physician directed you to take antibiotics prior to having your teeth cleaned? ☐ yes ☐ no

Do you have any disease, condition, or problem not listed above that we should know about?____

_____

*reviewed by*_____