Aesthetic Dental Center

MEDICAL HEALTH QUESTIONAIRE

Patient's Name _____ Date of Birth _____
Family Physician's Name _____
Physician's Address _____
Physician's Phone Number _____

1. Are you under a physician's care at this time? YES NO
   Since when _____ Why? _____
2. Are you taking any medications at this time, including birth control? YES NO
   If yes, please specify: _____
3. Are you allergic to penicillin, codeine, local anesthetics, tranquilizers or any other medications? YES NO
   If yes, please specify: _____
4. *Women:* Are you pregnant or suspect you may be? YES NO
   If yes, when is your due date? _____
5. Do you have, or have you had, any of the following diseases or conditions: (please circle)

Artificial Heart Valve	YES	NO	Hepatitis: Type _____	YES	NO
AIDS/HIV+	YES	NO	High Blood Pressure	YES	NO
Angina	YES	NO	Jaundice	YES	NO
Arthritis	YES	NO	Joint Prosthesis	YES	NO
Asthma	YES	NO	Kidney Disease	YES	NO
Bleeding Problems	YES	NO	Latex Allergy	YES	NO
Blood Disorders	YES	NO	Liver Problems	YES	NO
Cancer	YES	NO	Low Blood Pressure	YES	NO
Chemo/Radiation Therapy	YES	NO	Lung Disease	YES	NO
Cosmetic Surgery	YES	NO	Pacemaker	YES	NO
Diabetes	YES	NO	Psychiatric Care	YES	NO
Drug Addiction	YES	NO	Rheumatic Fever	YES	NO
Emphysema	YES	NO	Smoke/Chew Tobacco	YES	NO
Epilepsy/Seizure Disorders	YES	NO	Stroke	YES	NO
Glaucoma	YES	NO	Thyroid Problems	YES	NO
Heart Attack	YES	NO	TMJ disorder	YES	NO
Heart Surgery	YES	NO	Tuberculosis	YES	NO
Heart Murmur	YES	NO	Ulcer	YES	NO
Heart Problems	YES	NO			

6. Do you have any disease condition, or problem not listed?
   If yes, please specify: _____

I certify that the above information is complete and accurate. I will inform my dentist of any change in my health and/ or medication.

Patient's Signature _____ Date _____
(Parent or Guardian if patient is a minor)
Doctor's Signature _____ Date _____
Antibiotic Prophylaxis? YES or NO

Please list additional medications being taken.

_____

_____

_____

MEDICAL HEALTH UPDATE – Please verify changes in your health status at regular intervals

Date	Change in Health Status?	Signature
_____	YES NO	_____
_____	YES NO	_____
_____	YES NO	_____
_____	YES NO	_____
_____	YES NO	_____
_____	YES NO	_____
_____	YES NO	_____
_____	YES NO	_____
_____	YES NO	_____
_____	YES NO	_____
_____	YES NO	_____
_____	YES NO	_____
_____	YES NO	_____
_____	YES NO	_____
_____	YES NO	_____
_____	YES NO	_____
_____	YES NO	_____