Berkshire
DENTAL ARTS

Medical History Questionnaire

Patient Name: Date of Birth:

Please take the time to answer the following questions to the best of your ability. Collecting an accurate and thorough medical history is the first and most important step in ensuring that our office can provide you with safe, personally-tailored dental care.

Are you having pain or discomfort at this time? ◯ Yes ◯ No If yes:____

Do you feel very nervous about having dental treatment? ◯ Yes ◯ No If yes:____

Have you ever had a bad experience in a dental office? ◯ Yes ◯ No If yes:____

Have you been a patient in the hospital or had any major surgeries during the past two years? ◯ Yes ◯ No If yes:____

Have you been under the care of a medical doctor during the past two years (primary care or otherwise)? ◯ Yes ◯ No If yes:____

Are you currently taking any medications or drugs? ◯ Yes ◯ No If yes, please list:_______________________________
____

Are you allergic to (i.e. itching, rash, swelling of hands/feet/eyes) or made sick by penicillin, aspirin, codeine, or any other drugs? ◯ Yes ◯ No If yes:____

Do you have any other allergies? ◯ Yes ◯ No If yes:____

Have you ever had any excessive bleeding requiring special treatment? ◯ Yes ◯ No If yes:____

Have you ever taken Fosamax, Boniva, Actonel, or any medication containing bisphosphonates? ◯ Yes ◯ No If yes:____

Have you ever undergone radiation or chemotherapy? ◯ Yes ◯ No If yes:____

Women: Are you…
◯ Pregnant/trying to get pregnant? ◯ Nursing? ◯ Taking oral contraceptives?

Do you now or have you ever used tobacco or nicotine in any form? ◯ Yes ◯ No If yes, describe average use:_____________________
____

Do you drink alcohol? ◯ Yes ◯ No If yes, describe average use:_____________________

Do you use any recreational drugs? ◯ Yes ◯ No If yes:____

Do you use any over-the-counter vitamins or supplements? ◯ Yes ◯ No If yes:____

(OVER)

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Do you have, or have you ever had, any of the following:

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
High blood pressure	◯ Yes	◯ No	Asthma	◯ Yes	◯ No	Diabetes	◯ Yes	◯ No
Heart failure	◯ Yes	◯ No	Arthritis	◯ Yes	◯ No	Artificial heart valve	◯ Yes	◯ No
Heart disease or attack	◯ Yes	◯ No	Rheumatic fever	◯ Yes	◯ No	Artificial joint	◯ Yes	◯ No
Angina pectoris	◯ Yes	◯ No	Sinus troubles	◯ Yes	◯ No	Kidney problems	◯ Yes	◯ No
Heart murmur	◯ Yes	◯ No	Thyroid disease	◯ Yes	◯ No	Stroke	◯ Yes	◯ No
Congenital heart lesions	◯ Yes	◯ No	Radiation therapy	◯ Yes	◯ No	Tuberculosis (TB)	◯ Yes	◯ No
Heart pacemaker	◯ Yes	◯ No	Chemotherapy (cancer)	◯ Yes	◯ No	Emphysema	◯ Yes	◯ No
Heart surgery	◯ Yes	◯ No	Cortisone medications	◯ Yes	◯ No	High cholesterol	◯ Yes	◯ No
Anemia	◯ Yes	◯ No	Pain in jaw joint(s)	◯ Yes	◯ No	Hepatitis C	◯ Yes	◯ No
Ulcers	◯ Yes	◯ No	Hemophilia	◯ Yes	◯ No	Hepatitis B	◯ Yes	◯ No
Glaucoma	◯ Yes	◯ No	Scarlet fever	◯ Yes	◯ No	Liver disease	◯ Yes	◯ No
Auto-immune disease	◯ Yes	◯ No	Sickle cell disease	◯ Yes	◯ No	Jaundice	◯ Yes	◯ No
HIV or AIDS	◯ Yes	◯ No	Bruise easily	◯ Yes	◯ No	Drug or alcohol addiction	◯ Yes	◯ No
Venereal disease	◯ Yes	◯ No	Blood transfusions	◯ Yes	◯ No	Epilepsy or seizures	◯ Yes	◯ No
Herpes	◯ Yes	◯ No	Dry mouth	◯ Yes	◯ No	Fainting or dizzy spells	◯ Yes	◯ No
Cold sores	◯ Yes	◯ No	Nervousness	◯ Yes	◯ No	Psychiatric treatment	◯ Yes	◯ No

IF YES to any of the above, please explain in the space below:

When you go up stairs or take a walk, do you ever have pain in your chest, shortness of breath, or fatigue? ◯ Yes ◯ No

Do your ankles swell during the day? ◯ Yes ◯ No

Do you have to prop yourself up in bed to sleep well? ◯ Yes ◯ No

Have you gained or lost more than 10 pounds in the past year? ◯ Yes ◯ No

Do you ever wake up from sleep short of breath? ◯ Yes ◯ No

Are you on a special diet? ◯ Yes ◯ No

Have you ever had any serious illness not listed above? IF YES please describe below: ◯ Yes ◯ No

____

____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform my dentist and her team at the next appointment without fail.

____ ______________________

Signature of patient, parent, or guardian Date