Paul C. Kazmer, DMD, MS
Periodontics • Implants

PATIENT NAME:_____
BIRTH DATE:_____

MEDICAL-DENTAL HEALTH HISTORY QUESTIONNAIRE

DATE:_____

DIRECTIONS TO THE PATIENT: The following information about your health history is very important for us to provide you with the best possible dental care in a safe way. Incorrect information may be dangerous to your health. **ALL** questions must be answered completely and accurately. If you don't understand a question, or are unsure of the answer, or want to discuss it with the dentist, circle its number or letter, This Health History Questionnaire will become a part of the patient's dental record and will be considered confidential information.

Name of Your Physician:_____ Office Telephone:_____

Address of Your Physician_____

1. Are you in good health? ..... ☐Yes ☐ No ☐ Don't Know
2. Has there been any change in your health in the last year? ..... ☐Yes ☐No ☐ Don't Know
   If yes, explain:_____
3. Have you ever been hospitalized, had a major operation or serious illness? ..... ☐Yes ☐No ☐Don't Know
   If yes, explain: _____
4. Date of your last visit to the doctor:_____ Reason for last visit:_____

   _____
5. Are you currently receiving treatment or regular medical care by your doctor? ..... ☐Yes ☐No ☐ Don't Know
   If yes, for what condition(s)? _____
   _____
6. Are you taking any of the following medications:
   a. Antibiotics or sulfa drugs ..... ☐ Yes ☐No ☐Don't Know
   b. Anticoagulant (blood thinners) ..... ☐ Yes ☐No ☐Don't Know
   c. Medication for high blood pressure ..... ☐ Yes ☐No ☐Don't Know
   d. Cortisone (steroids) ..... ☐ Yes ☐No ☐Don't Know
   e. Tranquilizers ..... ☐ Yes ☐No ☐Don't Know
   f. Antihistamines ..... ☐ Yes ☐No ☐Don't Know
   g. Aspirin, Advil Nuprin, Motrin or Naprosyn ..... ☐ Yes ☐No ☐Don't Know
   h. Insulin, tolbutamide (Orinase) or other drugs for diabetes ..... ☐ Yes ☐No ☐Don't Know
   i. Digitalis, Nitroglycerin or other drugs for heart trouble ..... ☐ Yes ☐No ☐Don't Know
   j. Birth control pills or other hormones ..... ☐ Yes ☐No ☐Don't Know
   k. Synthroid or other thyroid medication ..... ☐ Yes ☐ No ☐ Don't Know
   l. AZT or other drugs for HIV ..... ☐ Yes ☐ No ☐ Don't Know
   m. Bisphophanates, Fosamax, Actonel, Boniva, Zometa, Aredia (current or past ..... ☐ Yes ☐No ☐ Don't Know
   n. Please LIST ALL medications you take (prescribed or over the counter):
   _____
   _____
7. Have you had any allergic or unusual reactions to any substance or medication?..... ☐Yes ☐No ☐Don't Know
   If yes, specify what substance/medications, and what reactions_____

HAVE YOU EVER BEEN TREATED BY A DOCTOR FOR: *(Check your response & underline any condition(s))*

8. Damaged heart valves, artificial heart valves, heart murmur, rheumatic fever, rheumatic heart disease, congenital heart problem? ☐ Yes ☐ No ☐ Don't Know
9. Do you have an artificial joint? ☐ Yes ☐ No ☐ Don't Know
10. Heart trouble, heart attack, high blood pressure, stroke? ☐ Yes ☐ No ☐ Don't Know
    a. Do you have pain in your chest upon exertion? ☐ Yes ☐ No ☐ Don't Know
11. Severe or frequent headaches? Sinus Problems? ☐ Yes ☐ No ☐ Don't Know
12. Blood disorders such as anemia or hemophilia? ☐ Yes ☐ No ☐ Don't Know
13. Breathing problems, emphysema, tuberculosis or other lung problems? ☐ Yes ☐ No ☐ Don't Know
14. Asthma, hay fever or hives? ☐ Yes ☐ No ☐ Don't Know
15. Stomach or intestinal ulcers? ☐ Yes ☐ No ☐ Don't Know
16. Cancer, x-ray treatments, or chemotherapy? ☐ Yes ☐ No ☐ Don't Know
17. Thyroid trouble? ☐ Yes ☐ No ☐ Don't Know
18. Diabetes or blood sugar problems? .....Last hA1c & Date:_____ ☐ Yes ☐ No ☐ Don't Know
19. Hepatitis, jaundice, or liver disease? ☐ Yes ☐ No ☐ Don't Know
20. Kidney infections, frequent urination, or renal (kidney) dialysis? ☐ Yes ☐ No ☐ Don't Know
21. Stroke, seizures, fainting spells, numbness or other neurological problems? ☐ Yes ☐ No ☐ Don't Know
22. Syphilis, gonorrhea, or genital herpes, sexually transmitted disease? ☐ Yes ☐ No ☐ Don't Know
23. AIDS, AIDS-related condition or HIV positive? ☐ Yes ☐ No ☐ Don't Know
24. Arthritis, rheumatism, autoimmune diseases (ex. lupus)? ☐ Yes ☐ No ☐ Don't Know
25. Phobias, anxieties, depression, psychoses, fears, or other mental problems? ☐ Yes ☐ No ☐ Don't Know
26. For **women**, are you pregnant or do you think you may be pregnant? ☐ Yes ☐ No ☐ Don't Know
27. Are there any other problems about your health that you know of? ☐ Yes ☐ No ☐ Don't Know

    If yes, describe: _____

HABITS AND PERSONAL HISTORY:

28. Do you now or have you ever used recreational drugs (besides alcohol or tobacco)? ... ☐Yes ☐No
29. Do you smoke? ... ☐Yes ☐No If so, How many cigarettes/packs daily? _____ How many years? _____
30. Do you vape? .... ☐ Yes ☐No
    a. If you smoked/vaped in the **past,** how many packs per day did you smoke? How many years ____ Packs/Day ____
    b. If you smoked/vaped in the **past,** when did you quit? ____Yrs ago
    c. If you smoke/vape, are you interested in help quitting? ☐Yes ☐No
30. How many drinks of beer, wine or liquor do you have per day? ____Drinks per Day

SIGNATURE OF PATIENT: I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes in my medical or dental status to the dentist at the earliest possible time, and I agree to do so. I give my permission to the dentist to obtain from my physician or dentist, any additional information regarding my medical history needed to provide me the best dental treatment possible.

PERSON COMPLETING FORM: Signature:_____ Date:_____

If other than patient, indicate relationship:_____

Do not write below this line

SIGNATURE, ATTENDING DENTIST:_____DMD, MS Date:_____

ASA Score: _____ MP Score: _____