# Antigo Dental Clinic, LLC

## MEDICAL AND DENTAL INFORMATION QUESTIONNAIRE

Patient Name

Date of Birth

1. Reason for visit: ____________________

2. Are you having any discomfort at this time? ____________

3. Previous dentist: Name and City ____________________
   a. Date of last visit ____________
   b. Date of last x-rays ____________

4. Have you had problems with previous dental care? ____________

## MEDICAL INFORMATION

If **"YES"** to any of the following items or if you are unsure, please explain in the space on the reverse side.

| Yes | No | |
|---|---|---|
| ❑ | ❑ | 5. Has there been any change in your general health within the past year? |
| | | 6. Your last physical examination was on: ____________ |
| | | 7. Name and city of physician: ____________ |
| ❑ | ❑ | 8. Are you now under the care of a physician? |
| ❑ | ❑ | 9. Have you been hospitalized for any surgical operation or serious illness? List type of surgery and year performed. ____________ |
| | | 10. Do you **have** or have you **had** any of the following **Cardiovascular Conditions?** |
| ❑ | ❑ | a. History of bacterial endocarditis |
| ❑ | ❑ | b. Congenital heart defect |
| ❑ | ❑ | c. Vascular disease |
| ❑ | ❑ | d. Heart surgery\Angioplasty |
| ❑ | ❑ | e. Vascular surgery |
| ❑ | ❑ | f. Pacemaker |
| ❑ | ❑ | g. Prosthetic heart valve |
| ❑ | ❑ | h. High blood pressure |
| ❑ | ❑ | i. Stroke |
| ❑ | ❑ | j. Heart attack (Heart trouble) |
| ❑ | ❑ | k. Angina |
| ❑ | ❑ | l. Heart transplant |
| ❑ | ❑ | m. Other cardiovascular problems: Describe: ____________ |
| | | **Other conditions?** |
| ❑ | ❑ | n. Liver disease, jaundice |
| ❑ | ❑ | o. Hepatitis |
| ❑ | ❑ | p. Liver transplant |
| ❑ | ❑ | q. Diabetes |
| ❑ | ❑ | r. Kidney trouble, dialysis, transplant |
| ❑ | ❑ | s. Thyroid problems |
| ❑ | ❑ | t. Tonsillitis |
| ❑ | ❑ | u. Sinus problems |
| ❑ | ❑ | v. Arthritis, Rheumatism |
| ❑ | ❑ | w. Asthma |
| ❑ | ❑ | x. Breathing or respiratory problems |
| ❑ | ❑ | y. Joint replacement Type ________ Date ________ |
| ❑ | ❑ | z. Prosthetic devices or implants: Type ____________ |
| ❑ | ❑ | aa. Neurological problems |
| ❑ | ❑ | bb. Psychiatric care |
| ❑ | ❑ | cc. Anemia |
| ❑ | ❑ | dd. Cancer What kind ____________ |
| ❑ | ❑ | ee. Hemophilia, other bleeding disorders |
| ❑ | ❑ | ff. Tuberculosis |
| ❑ | ❑ | gg. HIV-infection |
| ❑ | ❑ | hh. AIDS |
| ❑ | ❑ | ii. Eating disorder |
| ❑ | ❑ | jj. Stomach ulcers |
| ❑ | ❑ | kk. Use illigal drugs |
| ❑ | ❑ | ll. Excessive alcohol consumption How many per day? ________ |
| | | 11. Do you **have** or have you **had:** |
| ❑ | ❑ | a. Chest pain upon exertion? |
| ❑ | ❑ | b. Heartburn, Acid Reflux? |
| ❑ | ❑ | c. Fainting spells or seizures? |
| ❑ | ❑ | d. Hearing impairment? |
| ❑ | ❑ | e. Persistent cough, cough up blood? |
| | | 12. Have you had any of the following: |
| ❑ | ❑ | a. Abnormal bleeding (after tooth extraction, surgery, etc.)? |
| ❑ | ❑ | b. Bruise easily? |
| ❑ | ❑ | c. Radiation or Chemotherapy? |
| ❑ | ❑ | d. Blood transfusion (Yr _____)? |
| ❑ | ❑ | e. Delayed healing? |
| | | 13. Are you allergic to, or have you had any reactions to: |
| ❑ | ❑ | a. Local anesthetic? |
| ❑ | ❑ | b. Penicillin, other antibiotics? |
| ❑ | ❑ | c. Latex? |
| ❑ | ❑ | d. Aspirin, Ibuprofen or Tylenol? |
| ❑ | ❑ | e. Metals (Amalgam, Nickel, etc.)? |
| ❑ | ❑ | f. Codeine? |
| ❑ | ❑ | g. Other ____________ |
| | | 14. Do you have any disease, condition, or problem not listed above that we should know about? ____________ |
| ❑ | ❑ | 15. Are you taking a blood thinner? |
| ❑ | ❑ | 16. Are you taking any medications for osteoporosis? |
| ❑ | ❑ | 17. Do you need to take an antibiotic premedication? |
| ❑ | ❑ | 18. Medications being taken now - |

| Drug: | What for? |
|---|---|
| | |
| | |
| | |
| | |

| Yes | No | 19. Women |
|---|---|---|
| ❑ | ❑ | a. Are you taking contraceptives? |
| ❑ | ❑ | b. Are you pregnant? |
| ❑ | ❑ | c. Are you nursing presently? |