

# HOLLAND FAMILY DENTISTRY, P.C.

## Medical History Questionnaire

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Occupation \_\_\_\_\_

### Answer Yes or No (check appropriate box)

Have you ever been diagnosed with:

- |   |                          |     |                          |    |
|---|--------------------------|-----|--------------------------|----|
| High blood pressure .....                 | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Heart disease – angina .....              | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| - heart attack .....                      | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| - irregular heart beat .....              | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| - heart murmur .....                      | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| - rheumatic heart disease .....           | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| - other .....                             | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Diabetes .....                            | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Lung disease – asthma .....               | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| - emphysema .....                         | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| - pneumonia .....                         | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| - bronchitis .....                        | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Bleeding or Clotting disorder .....       | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Hepatitis .....                           | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Psychiatric problems - anxiety .....      | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| - other .....                             | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Nervous system disease - depression ..... | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| - epilepsy .....                          | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| - migraines .....                         | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| - other .....                             | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Kidney disease .....                      | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Gastrointestinal disease .....            | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Aids or HIV Infection .....               | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Joint Replacement .....                   | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Are you or Could you be pregnant .....    | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Are you taking birth control pills .....  | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Other medical problems .....              | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |

Please list other medical problems \_\_\_\_\_  
\_\_\_\_\_

Do you smoke  Yes  No – If yes, how much \_\_\_\_\_ for how long \_\_\_\_\_

Do you use alcohol or recreational drugs  Yes  No – If yes, how much \_\_\_\_\_ how often \_\_\_\_\_

Do you regularly use aspirin  Yes  No – If yes, how much \_\_\_\_\_ how often \_\_\_\_\_

Dr./Hygienist Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- Allergic to: Local Anesthetic .....  Yes  No  
Antibiotics. ....  Yes  No  
Latex. ....  Yes  No  
Other. ....  Yes  No

Please list \_\_\_\_\_  
\_\_\_\_\_

Physician's Name \_\_\_\_\_

Phone Number \_\_\_\_\_

List all medications you are taking \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List past surgical procedures: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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When was your last dental visit? \_\_\_\_\_

Previous Dentist Name \_\_\_\_\_

How often do you brush you teeth? \_\_\_\_\_

How often do you floss your teeth? \_\_\_\_\_

When was your last Full Mouth X-Ray taken? \_\_\_\_\_

Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_