Name: _____ Birthdate: _____ Age: _____
LAST FIRST MIDDLE INITIAL

Physician: _____ Physician's Phone: _____

Date of last appointment with physician: _____ Date of last physical exam: _____

MEDICAL CONDITIONS

Please circle any of the following that you have had or have at present:

Hypoglycemia
Heart Failure
Heart Disease or Attack
Angina Pectoris
High Blood Pressure
Heart Murmur (Ailment)
Rheumatic Fever
Congenital Heart Lesions
Scarlet Fever
Artificial Heart Valve
Heart Pacemaker
Heart Surgery
Artificial Joint

Anemia
Stroke
Kidney Trouble
Ulcers
Porphyria
Emphysema
Cough
Tuberculosis (TB)
Asthma
Hay Fever
Sinus Trouble
Allergies or Hives
Diabetes

Thyroid Disease
X-Ray or Cobalt Treatment
Chemotherapy (Cancer, Leukemia)
Arthritis
Rheumatism
Cortisone Medicine
Glaucoma
Pain in Jaw Joints
AIDS
Hepatitis A (infectious)
Hepatitis B (serum)
Liver Disease
Yellow Jaundice

Blood Transfusion
Drug Addiction
Hemophilia
Venereal Disease (Syphilis, Gonorrhea)
Cold Sores
Genital Herpes
Epilepsy or Seizures
Fainting or Dizzy Spells
Nervousness
Psychiatric Treatment
Sickle Cell Disease
Bruise Easily
Stomach/Intestinal Disease

Do you have reason to believe that you may have any of the above conditions undiagnosed? ☐ Yes ☐ No

REMARKS: _____

MEDICAL QUESTIONNAIRE

	CIRCLE	
Are you having pain or discomfort at this time?	YES	NO
Have you been a patient in the hospital during the past two years?	YES	NO
Have you been under the care of a medical doctor during the past two years?	YES	NO
Have you ever had any excessive bleeding requiring special treatment?	YES	NO
Have you ever had radiation therapy?	YES	NO
When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired?	YES	NO
Do your ankles swell during the day?	YES	NO
Do you use more than two pillows to sleep?	YES	NO
Have you lost or gained more than ten 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
Has your medical doctor ever said you have a cancer or tumor?	YES	NO
Do you have any disease, condition, or problem not listed?	YES	NO
WOMEN: Are you pregnant now?	YES	NO
Are you practicing birth control?	YES	NO
Do you anticipate becoming pregnant?	YES	NO

DENTAL QUESTIONNAIRE

1. Have you ever had: (Please check)
   - a. Orthodontic Treatment ☐
   - b. Periodontic Treatment ☐
   - c. Tooth Extraction ☐
   - d. Other Dental Surgery ☐
   - e. Brushing & Flossing Instruction ☐
   - f. Novocaine or other Local Anesthetic ☐
   - g. Nitrous Oxide Gas ☐
   - h. A bad experience in a dental office ☐
2. When were your last X-rays taken? _____
3. By Whom? _____
4. How often do you brush you teeth? _____
5. How often do you floss your teeth? _____
6. How often do you replace your toothbrush? _____

(Check the following ONLY if Yes)

7. Are you experiencing any discomfort in your mouth right now? ☐
8. Do you ever experience any sensitivity in your mouth? ☐
9. Do you have a habit of grinding or clenching your teeth? ☐
10. Do you ever hear a clicking or popping noise when you chew? ☐
11. Do your gums ever bleed? ☐

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 the doctor of dentistry at the next appointment without fail.

_____ _____
Date *Signature of Patient, Parent or Guardian*

MEDICATION

Please check any medication you are presently taking ar have taken within the last two years.

- Analgesic (Aspirin, etc.) ☐
- Birth Control Pills ☐
- Tranquilizers ☐
- Blood Thinners ☐
- Hypertension Drugs ☐
- Antihistamine (Allergy/Cold Drugs) ☐
- Valium ☐
- Heart Drugs ☐
- Antibiotics (Penicillin, etc.) ☐
- Diet Pills ☐
- Water Pills (Diuretics) ☐
- Topical Skin Medication ☐
- Vitamins ☐
- Other (Please indicate) ☐
- Tobacco Usage ☐

REMARKS: _____

ALLERGIES

Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by:

- Barbiturates ☐
- Penicillin ☐
- Sulfa Drugs ☐
- Novocaine (or other Caine drugs) ☐
- Pollen ☐
- Milk ☐
- Bee Stings ☐
- Eggs ☐
- Feathers ☐
- Dust ☐
- Other (Please indicate) ☐

REMARKS: _____

MEDICAL HISTORY/PHYSICAL EVALUATION UPDATE

Date	Addition

MCNERNEY DENTAL

MEDICAL/DENTAL HISTORY

FORM 026545 N/04/03 ITEM 8101