

Medical History Questionnaire

NAME: _____

DATE: _____

PERSONAL Medical History (these questions pertain to you)

Do you have a history of having:

Hepatitis	Yes	No
Damage to heart valves	Yes	No
Artificial hip or joint	Yes	No
Major illness/Cancer	Yes	No
Blood transfusion	Yes	No
Wound infection	Yes	No
Prior operations	Yes	No
Heart disease	Yes	No
High/Low Blood Pressure	Yes	No
Diabetes	Yes	No
Do you take antibiotics prior to seeing your dentist	Yes	No

If you answered YES to any of the above, please explain: _____

SOCIAL History (these questions pertain to you)

Tobacco use	Yes	No	How much? _____
Caffeine	Yes	No	How much? _____
Alcohol	Yes	No	How much? _____
Regular exercise	Yes	No	
Street drugs	Yes	No	
Tanning	Yes	No	
Wear sunblock	Yes	No	
Do you live alone	Yes	No	
Your occupation	_____		

Skin do you have a history of having:

Skin Cancer	Yes	No
Melanoma (mole cancer)	Yes	No
Hayfever, asthma, allergies	Yes	No
Other skin conditions	Yes	No

What kind do you use? Shower soap _____
Laundry soap _____
Fabric softener _____

FAMILY Medical History (these questions pertain to any of your blood relatives)

Psoriasis	MOTHER	FATHER	BLOOD RELATIVE
Hayfever, asthma, allergies	MOTHER	FATHER	BLOOD RELATIVE
Eczema	MOTHER	FATHER	BLOOD RELATIVE
Diabetes	MOTHER	FATHER	BLOOD RELATIVE
Skin Cancer	MOTHER	FATHER	BLOOD RELATIVE
Other Cancer	MOTHER	FATHER	BLOOD RELATIVE
Melanoma	MOTHER	FATHER	BLOOD RELATIVE
High Blood Pressure	MOTHER	FATHER	BLOOD RELATIVE
Heart disease	MOTHER	FATHER	BLOOD RELATIVE
Arthritis	MOTHER	FATHER	BLOOD RELATIVE

DO YOU HAVE A HISTORY OF LATEX ALLERGY? YES OR NO

IF YOU ANSWERED YES PLEASE GO TO THE FRONT DESK FOR ADDITIONAL INFORMATION UPON YOUR ARRIVAL.