Date: _____

Medical/Dental Health Questionnaire

First Name: _____ Last Name: _____

Home Phone: _____ Cell Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Married: _____ Single: _____

Date of Birth: _____ Soc Sec #: _____

Email: _____

Dental Insurance: _____

Subscriber name: _____ Subscriber Date of Birth: _____

Sub #: _____ Group # _____

1. Are any teeth currently bothering you? _____

_____

2. Are any of your teeth sensitive? _____

_____

3. Why are you seeking treatment? _____

_____

4. List the medications that you are currently taking (include prescription and non-prescription, over the counter, vitamins, oral contraceptives, etc) _____

_____

_____

5. Are you allergic to or have you had bad reactions to medications or anything else? (please list medication and type of reaction) _____

6. Does going to the dentist make you nervous? _____

7. Have you used nitrous oxide (laughing gas) before? _____

   if yes would you like to use it for future appointments? _____

Shumway Dental

1. Have you had or do you currently have any of the following. Please explain any YES answers:

- Do you have any bleeding disorders NO YES: _____
- Have you ever been told that you need antibiotic premedication before dental procedures?
  NO YES: _____
- Are you pregnant? NO YES Due date:_____
- High blood pressure NO YES: _____
- Low blood pressure NO YES: _____
- Congenital heart defect NO YES: _____
- Heart problems NO YES: _____
- Heart murmur NO YES: _____
- Prosthetic heart valve or heart valve replacement?
  NO YES: _____
- Pacemaker NO YES: _____
- Chest pain NO YES: _____
- Rheumatic fever NO YES: _____
- Liver disease NO YES: _____
- Kidney disease NO YES: _____
- Malignant tumor/cancer treatment NO YES: _____
- Non-malignant tumor NO YES: _____
- Head/neck radiation treatment NO YES: _____
- Diabetes NO YES: _____
- Tuberculosis NO YES: _____
- Stroke NO YES: _____

Shumway Dental

- Epilepsy NO YES: _____
- Hepatitis NO YES: _____
- Joint replacement NO YES: _____
- Swollen lymph glands NO YES: _____
- Sinus problems NO YES: _____
- Arthritis NO YES: _____
- AIDS/HIV NO YES: _____
- Venereal disease NO YES: _____
- Anemia NO YES: _____
- Asthma NO YES: _____
- Do you smoke? NO YES: _____
- Do you have a history of narcotic abuse? NO YES: _____
- Do you have a history of Alcohol abuse? NO YES: _____
- Nervous disorder/psychiatric care NO YES: _____
- Blood thinners NO YES: _____
- Unintentional weight loss NO YES: _____
- Thyroid troubles NO YES: _____
- Depression NO YES: _____

2. Have you been hospitalized at any point during the past five years?

NO YES: _____

_____ _____

Patient or Guardian Signature Date

_____ _____

Doctor Signature Date