MEDICAL QUESTIONNAIRE

BURLINGTON PERIODONTICS

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ALL INFORMATION GIVEN WILL BE TREATED AS STRICTLY CONFIDENTIAL

Full Name:	Date of birth (mm/dd/yy):	
Address (please include city):		Postal Code:
Home phone number:	Business phone number:	
Cell phone number:	Email address:	
Medical doctor's name:	Phone number:	
Medical doctor's address:		

Notes:

To provide the best possible care for our patients, all patients are asked to fill out this questionnaire. Please answer the following questions as accurately as possible. If you have any questions, please ask for assistance.

1. Are you being treated for any medical condition at the present or have you been treated within the past year?..... ❑ Yes ❑ No
*If so why?*_____

2. Was your last medical check-up within the past one year? …….❑ Yes ❑ No

3. Do you have any heart (heart surgery, artificial valve/valve repair, congenital heart disease) or blood pressure problems?……..……...❑ Yes ❑ No

4. Have you had a heart attack or stroke? ……❑ Yes ❑ No

5. Are you taking any medications of any kind? .....❑ Yes ❑ No
*If yes, please list what kinds:*_____

6. Do you take any blood thinners (e.g. Coumadin, Pradax, Xarelto, Eliquis, Clopidogrel, Aspirin or other)?.....…… ❑ Yes ❑ No

7. Do you have allergies (e.g. Penicillin? latex?) ……❑ Yes ❑ No
*If yes, please list:*_____

8. Have you ever had reactions to any medicines or injections? ……❑ Yes ❑ No
*If yes, please list:*_____

MEDICAL QUESTIONNAIRE CONTINUED

9. Do you have Hepatitis, jaundice or liver disease? ……...❑ Yes ❑ No

10. Do you have any condition that could affect your immune system?
(e.g. Leukemia, AIDS, HIV infection?)…….. ❑ Yes ❑ No

11. Do you have any tendency to bruise or bleed easily?..... ❑ Yes ❑ No

12. Have you ever been hospitalized for any illness/operations?..... ❑ Yes ❑ No
*If yes, for what:*_____

13. Do you have diabetes?..... ❑ Yes ❑ No

14. For women only, are you pregnant?..... ❑ Yes ❑ No

15. Have you ever had any of the following?
❑ Chest pain ❑ Shortness of breath ❑ Lung disease ❑ Bone strengthening pills e.g. Actonel, Prolia
❑ Tuberculosis ❑ Asthma ❑ Cancer ❑ Steroid therapy ❑ Diabetes ❑ Stomach ulcers ❑ Prosthetic joints
❑ Arthritis ❑ Seizures ❑ Kidney disease ❑ Osteoporosis ❑ None

16. Do you have any other conditions not listed above?..... ❑ Yes ❑ No
*If yes, for what:*_____

17. Are there any diseases or medical problems that run in your family?
(e.g. Diabetes, cancer or heart disease) ……...❑ Yes ❑ No
*If yes, what:*_____

18. How often do you brush your teeth?_____ How often do you floss your teeth?_____

19. Are you nervous during dental treatment? ……❑ Yes ❑ No
If yes, how nervous are you? ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ Very nervous

20. Is there anything in particular that makes you nervous with dental treatment? ……❑ Yes ❑ No
*If yes, what:*_____

21. Do you smoke ❑ Yes ❑ No ❑ Quit # Packs:_____ # Years:_____

22. Do you drink alcoholic beverages on a regular basis?
……..❑ Yes ❑ No

23. Do you use recreational drugs?.....…….❑ Yes ❑ No

I acknowledge that the information given above is true to the best of my knowledge and that the questions have been reviewed with me. Should there be any change to my present health status in the future, I will advise the clinic staff. I have been informed that my physician may be contacted by letter or telephone in order to complete details of my medical history. I hereby consent to my physician providing the clinic with any information in this regard, which may help ensure safe dental treatment.

Signature:_____ Date:_____