THE DENTAL CENTER OF EAGAN

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MEDICAL QUESTIONAIRE

Name:________________________________ Date:________________

Please list the name, address and phone number of your physician:

____

Do you have or have you had any of the following medical conditions? (please check yes or no)

YES	NO		YES	NO	
___	___	**Are you taking or *have you ever taken* Bisphosphonates for osteoporosis, multiple or other cancers (Fosamax, Actonel, Boniva, Aredia, Zometa, Reclast)?**			
___	___	Rheumatic fever or heart disease	___	___	Liver disease, jaundice
___	___	Heart murmur	___	___	Hepatitis
___	___	Congenital heart defect	___	___	Diabetes
___	___	Vascular disease	___	___	Kidney disease, dialysis
___	___	Heart surgery/ Angioplasty	___	___	Thyroid problems
___	___	Pacemaker	___	___	Seasonal Allergies
___	___	Prosthetic heart valve	___	___	Asthma
___	___	High blood pressure	___	___	Emphysema, lung problems
___	___	Stroke	___	___	Arthritis, rheumatism
___	___	Heart attack	___	___	Orthopedic pins or artificial joints
___	___	Chest pain (angina)	___	___	Tuberculosis
___	___	Anemia	___	___	Hemophilia, bleeding disorder
___	___	HIV, AIDS	___	___	Stomach ulcers
___	___	Glaucoma	___	___	Chemical dependency

Have you had any of the following?

YES	NO	
___	___	Chest pain upon exertion or with exercise ?
___	___	Fainting spells or seizures?
___	___	Ankle swelling or shortness of breath when lying down?
___	___	Recent or unusual weight loss?
___	___	Recent Diarrhea, Nausea, or Vomiting?
___	___	Persistent cough or cough up blood?
___	___	Abnormal bleeding or bruising after tooth extraction or surgery?
___	___	Radiation or Chemotherapy?
___	___	Recent cold, sore throat or respiratory tract infection?
___	___	TMJ problems, clicking, popping of the jaw or difficulty in opening or closing?
___	___	Allergic reaction to latex products?
___	___	Are you required to use pre-medication for dental appointments?

___ ___ Are you wearing contact lenses today?

___ ___ **Had anything to eat or drink in the last 6 hours?**

___ ___ Allergic reaction to penicillin or any other medications?

Please list all medications which you are allergic to: ____________________________________

____

Please list all medications and dosages that you are currently taking ______________________

____

Please provide your current weight __________ Our dental chairs hold up to 350 pounds. By initialing this statement you are aware that you are under our chair weight limit __________ (Initial)

	YES	NO
Are you taking any of the following medications:		
Antibiotics	___	___
Aspirin	___	___
Pain Medication	___	___
Corticosteroids	___	___
Insulin or sugar lowering pill	___	___
Blood thinners	___	___
Do you smoke or use smokeless tobacco?	___	___

How much per day? ______________ For how many years? ________________

Have you had any of the following dental services:

	YES	NO		YES	NO
Orthodontic treatment (Braces)	___	___	Oral Surgery	___	___
Gum treatment or surgery	___	___	Bite adjustment	___	___
Worn a splint or night guard	___	___	TMJ problems	___	___

<u>**Women**</u>	**YES**	**NO**
Are you taking contraceptives?	___	___
Are you pregnant, or chance you could be pregnant?	___	___
Are you currently nursing?	___	___

If any other medical conditions that you suffer from which are not listed above, please list and describe

____

What would you like to change about your smile?

____

To the best of my knowledge, the above information is complete and correct

____ **(date)**__________

signature of patient or guardian(if patient is under 18 years old)