Medical/ Dental Health Questionaire

Welcome to Zahnpraxis Mundwerk!

☐ *male* ☐ *female*

……..…..
Last Name *First Name* *Date of Birth*

Address ……..…..

……..…..
City *State* *Zip*

Why are you seeking treatment?

……

List the medications you are currently taking ……..

……..

Are you allergic to or have you had bad reactions to medications or anything else?

……

Have you had or do you currently have any of the following? Please explain any Yes answer:

Bleeding disorder?	☐ *yes*	☐ *no*	
Have you ever been told that you need antibiotic premedication before dental procedures?	☐ *yes*	☐ *no*	
Are you pregnant?	☐ *yes*	☐ *no*	*Due date:*
High blood pressure?	☐ *yes*	☐ *no*	
Low blood pressure?	☐ *yes*	☐ *no*	
Congenital heart defect?	☐ *yes*	☐ *no*	
Heart problems?	☐ *yes*	☐ *no*	
Heart murmur?	☐ *yes*	☐ *no*	
Prosthetic heart valve or heart valve replacement?	☐ *yes*	☐ *no*	
Pacemaker?	☐ *yes*	☐ *no*	
Rheumatic fever?	☐ *yes*	☐ *no*	
Sliver disease?	☐ *yes*	☐ *no*	
Kidney disease?	☐ *yes*	☐ *no*	
Malignant tumor/ cancer treatment?	☐ *yes*	☐ *no*	
Non- malignant tumor?	☐ *yes*	☐ *no*	

Head/ neck radiation treatment?	□ *yes*	□ *no*	
Diabetes?	□ *yes*	□ *no*	
Tuberculosis?	□ *yes*	□ *no*	
Stroke?	□ *yes*	□ *no*	
Epilepsy?	□ *yes*	□ *no*	
Hepatitis?	□ *yes*	□ *no*	
Swollen lymph glands?	□ *yes*	□ *no*	
Sinus problems?	□ *yes*	□ *no*	
Arthritis?	□ *yes*	□ *no*	
AIDS/ HIV?	□ *yes*	□ *no*	
Venereal disease?	□ *yes*	□ *no*	
Anemia?	□ *yes*	□ *no*	
Asthma?	□ *yes*	□ *no*	
Do you smoke?	□ *yes*	□ *no*	
Do you have a history of narcotic abuse?	□ *yes*	□ *no*	
Do you have a history of Alcohol abuse?	□ *yes*	□ *no*	
Nervous disorder/ psychiatric care?	□ *yes*	□ *no*	
Blood thinners?	□ *yes*	□ *no*	
Unintentional weight loss?	□ *yes*	□ *no*	
Thyroid troubles?	□ *yes*	□ *no*	
Depression?	□ *yes*	□ *no*	
Have you been hospitalized at any point during the past five years?	□ *yes*	□ *no*	
Are your teeth sensitive to	□ *hot/ cold*	□ *sweet*	□ *pressure*
Have you had any peridontal work?	□ *yes*	□ *no*	

Date Patient Signature