METROPOLITAN PERIODONTICS & IMPLANTOLOGY ASSOCIATES, P.A.

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Please complete and bring to your 1st appointment.

MEDICAL HEALTH QUESTIONNAIRE

Name: _____ email: _____ @ _____

Address: _____ City: _____ State: _____ Zip: _____

Tel: (H) _____ (W) _____ (C) _____ Date of Birth: _____

Height: _____ Weight: _____ Sex: _____

Marital Status: _____ Occupation: _____ Referred By: _____

Who would we contact, in the case of an emergency: _____ (Tel:) _____

	Yes	No
1. How do you estimate your general health: ☐ Good ☐ Fair ☐ Poor		
2. Has there been any change in your general health within the past year?	☐	☐
3. Are you now under the care of a physician?	☐	☐
a. If so, what is the condition being treated? _____		
b. Name, Address and Telephone of your physician? _____		
_____		
_____		
4. Do you need an antibiotic "Pre-medication" prior to dental appointments?	☐	☐
If so, for what condition do you premedicate? _____		
and, what antibiotic do you take? _____		
5. Have you had any serious illness or operation?	☐	☐

6. Do you have or have experienced any of the following:

☐ Rheumatic fever	☐ Stomach ulcers	☐ Glaucoma
☐ Congenital heart defects (Heart murmur)	☐ Allergies or Hay fever	☐ Arthritis
☐ Heart attack, stroke, circulation problems	☐ Cancer or Tumor	☐ Blood transfusion
☐ Diabetes	☐ Psychiatric therapy	☐ Anemia
☐ High or low blood pressure	☐ Tuberculosis	☐ Kidney problems
☐ Hepatitis, jaundice or liver problems	☐ Asthma or Sinus problems	☐ Immune deficiency disorders
☐ Fainting spells, seizures, or epilepsy	☐ Sexually transmitted disease	

7. Have you ever experienced any of the following:	Yes	No
Chest pain following exertion?	☐	☐
Shortness of breath after mild exercise?	☐	☐
Swelling of your ankles?	☐	☐
Do you sleep on more than 2 pillows?	☐	☐
Do you have shortness of breath when lying flat?	☐	☐
Do you urinate (pass water) more than 6 times a day?	☐	☐
Are you frequently thirsty?	☐	☐
Have you ever had a persistent cough or have coughed up blood?	☐	☐
Have you ever had abnormal bleeding after tooth extraction, surgery or trauma?	☐	☐
Do you bruise easily?	☐	☐

	Yes	No
8. Are you taking any medication, drugs or pills?	☐	☐
If so, what drugs are you taking: _____		
9. Are you allergic or have reacted poorly to:		
Local anesthetics	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa drugs.	☐	☐
Barbiturates, sedatives or sleeping pills.	☐	☐
Aspirin	☐	☐
Iodine	☐	☐
Codeine or other Narcotics	☐	☐
Other.	☐	☐
10. Have you unintentionally *gained* or *lost* more than 10 pounds in the past year?	☐	☐
11. Have you ever had *surgery* or *radiation* treatment to your *head* or *neck* region?	☐	☐
12. Are you taking any of the following:		
Antibiotics or sulfa drugs	☐	☐
Anticoagulants (blood thinners)	☐	☐
Medicine for high blood pressure	☐	☐
Cortisone (steroids).	☐	☐
Tranquilizers	☐	☐
Antihistamines	☐	☐
Aspirin	☐	☐
Insulin, tolbutamide (Orinase), or similar drugs	☐	☐
Digitalis or drugs for Heart problems	☐	☐
Nitroglycerin	☐	☐
Oral contraceptives or other Hormonal therapy	☐	☐
Other: _____		
13. Women:		
Are you pregnant?	☐	☐
Do you have any problems associated with your menstrual cycle?	☐	☐
Are you nursing?	☐	☐

14. Have you experienced any of the following:

- ☐ Tooth ache
- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Grinding of teeth
- ☐ Sensitivity to hot, cold or sweets
- ☐ Difficulty in wearing dentures
- ☐ Clicking, popping or discomfort of the jaw
- ☐ Food collection between teeth
- ☐ Loose teeth or fillings
- ☐ Pain when biting
- ☐ Sores or growths in your mouth
- ☐ TMJ problems

15. What is the name of your current Dentist: _____

_____

_____

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Date: _____ Signature: _____

Date: _____ Dentist Signature: _____