PERRI MALEK DMD

MEDICAL QUESTIONNAIRE

Patient Name: _____ **Date:** _____

Please check if you have any of the following medical conditions / medical problems:

1 ☐ AIDS / HIV Positive
2 ☐ Alcoholism
3 ☐ Allergies
Describe_____
_____
4 ☐ Anemia
5 ☐ Arthritis
6 ☐ Artificial Heart Valves
7 ☐ Artificial Joints
8 ☐ Asthma
9 ☐ Back problem
10 ☐ Blood Disease
11 ☐ Cancer
12 ☐ Chemotherapy
13 ☐ Circulation Problems
14 ☐ Cortisone Treatments
15 ☐ Cough, persistent
16 ☐ Cough up blood
17 ☐ Diabetes
18 ☐ Epilepsy
19 ☐ Fainting
20 ☐ Food Allergies
21 ☐ Glaucoma
22 ☐ Headaches, frequent
23 ☐ Headaches, migraines
24 ☐ Heart Murmur
25 ☐ Heart, any problems
Describe_____
_____
26 ☐ Hemophilia
27 ☐ Herpes
28 ☐ Hepatitis A B C
29 ☐ High Blood Pressure
30 ☐ Jaw Pain
31 ☐ Kidney disease
32 ☐ Liver disease
☐ Pregnancy
33 ☐ Mitral Valve Prolapse
34 ☐ Nervous problems
35 ☐ Pacemaker
36 ☐ Psychiatric Care
37 ☐ Radiation Treatment
38 ☐ Respiratory Disease
39 ☐ Rheumatic Disease
40 ☐ Seizure disorders
41 ☐ Shingles
42 ☐ Shortness of Breath
43 ☐ Skin Rash
44 ☐ Stroke
45 ☐ Surgical Implants
46 ☐ Swelling feet or ankles
47 ☐ Thyroid Problems
48 ☐ Tobacco use
49 ☐ Tuberculosis
50 ☐ Ulcers / Colitis

Known Allergies:

51 ☐ Local anesthetic
52 ☐ Aspirin
53 ☐ Penicillin
54 ☐ Codeine
55 ☐ Sulfa
56 ☐ Iodine
57 ☐ Latex
58 ☐ Other: _____

List any medications you are currently taking:

_____
_____
_____
_____

59 Pre-medication required _____
60 Consulting Physician _____
61 Pharmacy _____

Check if you have had any problems with the following:

62 ☐ Bad Breath
63 ☐ Bleeding, sensitive gums
64 ☐ Clicking or popping jaw: right or left
65 ☐ Food trapped between teeth
66 ☐ Grinding or clenching teeth
67 ☐ Loose teeth
68 ☐ Broken fillings
69 ☐ Periodontal treatment
70 ☐ Sensitivity to Cold
71 ☐ Sensitivity to hot
72 ☐ Sensitivity to Sweets
73 ☐ Sensitivity to Biting
74 ☐ Sores in Mouth
75 ☐ Staining

Authorization:

I have reviewed the information and answered all questions to the best of my knowledge. I understand this information will be used to determine the dental treatment I receive at this office and may be shared with other medical offices only as necessary. I will notify the office should any information change in the future.

Signature of patient, or parent if a minor: _____

Reviewed by: _____