Chalet Dental Medical History Questionnaire

Last Name ______________________ First Name ________________________ Middle Initial _____

Medical Doctor ___________________ Date of Last Physical ________________________________

Former Dentist ___________________ Date of Last Dental Visit ______________________________

1. **Please circle any of the following conditions which you have had or presently have:**

Heart Disease	Asthma	Kidney Trouble	Alcohol/Substance Abuse
High Blood Pressure	Pulmonary Disease	Liver Disease	Mental Health Condition
Heart Murmur/Defect	Emphysema	Hepatitis	Panic/Anxiety Attacks
Stroke	Tuberculosis (TB)	Epilepsy/Seizures	Cancer
Prolonged/Unusual Bleeding	Diabetes	Fainting/Dizzy Spells	Radiation Therapy
Arthritis	Ulcers	HIV Positive	Chemotherapy
Osteoporosis	Reflux (GERD)	Frequent Cold Sores	Sjoegren's Disease/ Dry Mouth
	Thyroid Disease		

2. YES NO Have you seen a medical doctor during the past 12 months?

3. YES NO Are you presently taking any medicine including over-the-counter or herbal remedies, or drugs including marijuana?
If yes, please list here: ________________ ________________ ________________
________________ ________________ ________________
________________ ________________ ________________

4. YES NO Are you allergic to any medicine or materials? (Including Penicillin, Codeine, Latex, etc)
If yes, please specify here: ____________________

(Allergy sticker here)

5. YES NO Have you had an implant or replacement of any joint, heart valve or body part?
If yes, please specify type & date here: ________________________________

6. YES NO Do you have any diseases or conditions not listed above? If yes, what are they? ______________

7. YES NO Do you use any form of tobacco? If yes, please circle type & frequency:
SMOKE: Cigarettes Cigars Pipe SMOKELESS: Chewing Tobacco Snuff or "Dip"
Frequency ____________________ Frequency ____________________________
Are you interested in quitting? YES NO

8. YES NO Do you use dental floss? If yes, how often? ________________

9. YES NO Do your gums bleed when you brush or floss?

10. YES NO Do you have a fear of having dental work done?

11. YES NO Are you having any discomfort at this time?

12. (Circle one) Do you use an ELECTRIC or MANUAL toothbrush?

13. YES NO Are you on well water?

14. YES NO FEMALES: Are you pregnant? (If yes, please circle trimester) 1 2 3

15. YES NO FEMALES: Are you currently taking birth control pills?

PATIENT SIGNATURE ________________________________ DATE ______________________

(Legal guardian if patient is a minor)