SUNY at Buffalo / School of Dental Medicine

File No. ☐☐☐☐☐☐

MEDICAL HISTORY QUESTIONNAIRE

Patient Name: _____

Weight _____ Height _____ ☐ Married ☐ Single Occupation _____ How Long _____

In the following questions, check yes or no, whichever applies.
Your answers are for our records and will be considered confidential.

		Yes	No
1	ARE YOU IN GOOD HEALTH	☐	☐
	a Has there been any change in your general health within the past year	☐	☐
2	MY LAST PHYSICAL EXAMINATION WAS ON		
3	ARE YOU NOW UNDER THE CARE OF A PHYSICIAN		
	a If so, what is the condition being treated		
4	THE NAME AND ADDRESS OF MY PHYSICIAN IS		
5	HAVE YOU HAD SERIOUS ILLNESS OR OPERATION	☐	☐
6	HAVE YOU BEEN HOSPITALIZED OR HAD A SERIOUS ILLNESS WITHIN THE PAST FIVE (5) YEARS		
	a If so, what was the problem		
7	DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS		
	a Rheumatic fever or rheumatic heart disease	☐	☐
	b Congenital heart lesions	☐	☐
	c Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)	☐	☐
	d Do you have pain in you chest upon exertion	☐	☐
	e Are you ever short of breath after mild exercise	☐	☐
	f Do your ankles swell	☐	☐
	g Do you get short of breath when you lie down, or do you require extra pillows when you sleep	☐	☐
	h Allergy	☐	☐
	i Asthma or hay fever	☐	☐
	j Hives or a skin rash	☐	☐
	k Fainting spells or seizures	☐	☐
	l Diabetes	☐	☐
	m Do you have to urinate (pass water) more than six (6) times a day	☐	☐
	n Are you thirsty much of the time	☐	☐
	o Does your mouth frequently become dry	☐	☐
	p Hepatitis, jaundice or liver disease	☐	☐
	q Arthritis	☐	☐
	r Inflammatory rheumatism (painful swollen joints)	☐	☐
	s Stomach ulcers	☐	☐
	t Kidney trouble	☐	☐
	u Do you have a persistent cough or cough up blood	☐	☐
	v Tuberculosis	☐	☐
	w Low blood pressure	☐	☐
	x Venereal disease	☐	☐
	y Other		
8	HAVE YOU HAD ABNORMAL BLEEDING ASSOCIATED WITH PREVIOUS EXTRACTIONS, SURGERY OR TRAUMA	☐	☐
	a Do you bruise easily	☐	☐
	b Have you ever required a blood transfusion	☐	☐
	If so, explain the circumstances		

		Yes	No
9	DO YOU HAVE ANY BLOOD DISORDER SUCH AS ANEMIA	☐	☐
10	HAVE YOU HAD SURGERY OR X-RAY TREATMENT FOR A TUMOR, GROWTH, OR OTHER CONDITION OF YOUR HEAD AND NECK	☐	☐
11	ARE YOU TAKING ANY DRUGS OR MEDICINE	☐	☐
	a If so, what:		
12	ARE YOU TAKING ANY OF THE FOLLOWING:		
	a Antibiotics or sulfa drugs	☐	☐
	b Anticoagulants (blood thinners)	☐	☐
	c Medicine for high blood pressure	☐	☐
	d Cortisone (steroids)	☐	☐
	e Tranquilizers	☐	☐
	f Insulin, tolbutamide (Orinase) or similar drug	☐	☐
	g Aspirin	☐	☐
	h Digitalis or drugs for heart trouble	☐	☐
	i Nitroglycerin	☐	☐
	j Other:		
13	ARE YOU ALLERGIC OR HAVE YOU REACTED ADVERSELY TO:		
	a Local anesthetics	☐	☐
	b Penicillin or other antibiotics	☐	☐
	c Sulfa drugs	☐	☐
	d Barbituates, sedatives or sleeping pills	☐	☐
	e Aspirin	☐	☐
	f Iodine	☐	☐
	g Other:		
14	HAVE YOU HAD ANY SERIOUS TROUBLE ASSOCIATED WITH ANY PREVIOUS DENTAL TREATMENT	☐	☐
	a If so, explain		
15	DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT	☐	☐
16	ARE YOU EMPLOYED IN ANY SITUATION WHICH EXPOSES YOU REGULARLY TO X-RAYS OR OTHER IONIZING RADIATION	☐	☐
17	DO YOU WEAR CONTACT LENSES	☐	☐
WOMEN:			
18	ARE YOU PREGNANT	☐	☐
19	DO YOU HAVE ANY PROBLEMS ASSOCIATED WITH YOUR MENSTRUAL PERIOD	☐	☐

BLOOD PRESSURE:

date	sitting	standing	right arm	left arm

RECORD HISTORY OF SMOKING AND ALCOHOLIC CONSUMPTION

REMARKS

I agree to notify in writing the Director of Patient Evaluation and Management or the Associated Dean for Clinical Affairs if there is a change in my medical status as reported above.

Signature of Patient Date

Signature of Dentist Date