# MEDICAL QUESTIONNAIRE

Patient Name ____________________________________________

Date ________________ Today's BP ____________________

## How may we reach you?

_______________________________________________________________
Email Address Phone Cell

## Emergency Contact

_______________________________________________________________
Name Relationship Phone

## Antiobiotic Pre-Medication required?

❍ Yes ❍ No For what reason? ____________________________

_______________________________________________________________
MD Requiring it Type Dosage Duration in Life

## CHECK if you HAVE or HAD any of the following

❍ High Blood Pressure
❍ Heart Attack
❍ Chest Pain
❍ Artificial Valves
❍ Stents/Bypass
❍ Pacemaker
❍ Heart Murmurs
❍ Afib/Ablation
❍ Mitral Valve Prolapsed
❍ Rheumatic Fever
❍ Swollen Feet/Ankles
❍ Circulation Problems
❍ Lung Disease
❍ Asthma
❍ Emphysema
❍ COPD
❍ Bronchitis
❍ Pneumonia
❍ TB
❍ Chronic Cough

❍ Cancer
❍ Biopsies
❍ Radiation Treatment
❍ Chemotherapy
❍ Thyroid Hypo/Hyper
❍ Osteoporosis
❍ Fibromyalgia
❍ Blood Disease
❍ Excessive Bleeding
❍ Anemia
❍ Autoimmune Disease
❍ Polio
❍ Lupus
❍ Shortness of Breath
❍ Seizure Disorder
❍ Epilepsy
❍ Nervous Disorder
❍ Psychiatric Care
❍ Autism
❍ Birth Defects

❍ Glaucoma
❍ Dementia
❍ Diabetes
❍ Liver Disease
❍ Hepatitis A B C
❍ Kidney Disease
❍ ALS
❍ MS
❍ Cerebral Palsy
❍ Parkinsons
❍ Joint Replacement
❍ Surgical Implants
❍ Shingles
❍ PTSD
❍ Colitis
❍ Arthritis
❍ AIDS/HIV Positive
❍ HPV
❍ Herpes
❍ Sexually Transmitted Disease

### IN THE PAST 5 YEARS HAVE YOU HAD

❍ Cortisone Treatment
❍ Back/Neck Problems
❍ Pregnancy
❍ Take Birth Control
❍ Acid Reflux
❍ GERD
❍ Heartburn
❍ Ulcer
❍ Fainting
❍ Dizziness
❍ Vertigo
❍ Headaches
Frequency? ________________
❍ Tabacco Spit/Smoke
❍ Insomnia
❍ Snoring
❍ Sleep Apnea
Do you wear a device? ______

## Known Allergies

❍ Local Anesthetic
❍ Aspirin
❍ Penicillin
❍ Codeine
❍ Sulfa
❍ Iodine
❍ Latex
❍ Other __________________

## Check if you have had any problems with the following

❍ Bad Breath
❍ Bleeding, Sensitive
❍ Clicking or Popping Jaw
❍ Right ❍ Left
❍ Food Trapping Between Teeth

❍ Loose Teeth
❍ Periodontal Treatment
❍ Staining
❍ Broken Fillings
❍ Grinding or Clenching Teeth

❍ Sores in Mouth
❍ Sensitivity to Cold
❍ Sensitivity to Hot
❍ Sensitivity to Sweets
❍ Sensitivity to Biting

**Dr. Mark J. Williamson, DDS**
3355 Cherry Ridge, Suite 216 | San Antonio, TX 78230
Office 210.341.2569 | Fax 210.308.9613
DrWilliamson@MJWdental.com | FrontDesk@MJWdental.com
**www.MJWdental.com**

# PHARMACY INFORMATION

Pharmacy Name ____________________________________________

Pharmacy Phone Number ____________________________________

## List of Physicians, Specialty, and Phone Number

____________________________________________ ____________________________________________

____________________________________________ ____________________________________________

____________________________________________ ____________________________________________

____________________________________________ ____________________________________________

## List of Medications & Reason for Taking

____________________________________________ ____________________________________________

____________________________________________ ____________________________________________

____________________________________________ ____________________________________________

____________________________________________ ____________________________________________

____________________________________________ ____________________________________________

____________________________________________ ____________________________________________

## List of any Supplements you Take

____________________________________________ ____________________________________________

____________________________________________ ____________________________________________

____________________________________________ ____________________________________________

## Other Information We Should Know

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

## Authorization

I have reviewed the information and answered all questions to the best of my knowledge. I understand that 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 of minor** ________________________________________ **Date** ____________________

**Provider Signature** ____________________________________________________________________

**Dr. Mark J. Williamson, DDS**
3355 Cherry Ridge, Suite 216 | San Antonio, TX 78230
Office 210.341.2569 | Fax 210.308.9613
DrWilliamson@MJWdental.com | FrontDesk@MJWdental.com
**www.MJWdental.com**