MARK J. WILLIAMSON, DDS

MEDICAL QUESTIONNAIRE

Patient Name: _____ **Date:** _____

Today's BP: _____ **Email Address:** _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under the care of a physician? Yes / No
If yes, please explain: _____
Have you been hospitalized or had a major operation in the last 5 years? Yes / No
If yes, please explain: _____

Have you ever taken Fosamax, Boniva, Actonel, Prolia, Forteo, or Reclast? Yes No
Have you ever had any difficulty with dental extractions or prolonged bleeding? Yes No
Have you ever had any adverse reaction to dental anesthesia? Yes No

CHECK if you HAVE or HAD any of the following.

- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Chest Pains
- ☐ Artificial Valves
- ☐ Stents/Bypass
- ☐ Stroke
- ☐ Pacemaker
- ☐ Heart Murmurs
- ☐ Atrial fibrillation /Ablation
- ☐ Mitral Valve Prolapse
- ☐ Rheumatic Fever
- ☐ Swollen Feet/Ankles
- ☐ Circulation Problems
- ☐ Lung Disease
- ☐ Asthma
- ☐ Emphysema
- ☐ COPD
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Chronic Cough
- ☐ Shortness of breath

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

- ☐ Glaucoma
- ☐ Dementia
- ☐ Diabetes
- ☐ Liver Disease
- ☐ Hepatitis A B C
- ☐ Kidney Disease
- ☐ ALS
- ☐ Multiple sclerosis
- ☐ Cerebral Palsy
- ☐ Parkinson's
- ☐ Joint Replacement

Antibiotics Required?
Yes No

- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Surgical Implants
- ☐ Shingles
- ☐ Colitis
- ☐ AIDS/HIV Positive
- ☐ Sexually transmitted disease

IN THE PAST 5 YEARS HAVE YOU HAD

- ☐ Cortisone Treatment
- ☐ Back/Neck Problems
- ☐ Pregnancy
  Nursing
- ☐ Take Birth Control
- ☐ Acid Reflux / GERD/Ulcers
- ☐ Fainting
- ☐ Dizziness
- ☐ Vertigo
- ☐ Headaches
  Frequency? _____
- ☐ Tobacco Spit/Smoke
- ☐ Controlled Substances
- ☐ Insomnia
- ☐ Snoring
- ☐ Sleep Apnea
  Do you wear a device? _____

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Please Describe any Other Medical Conditions Not Described Above

_____

_____

Allergies:

☐ Local Anesthetic ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Sulfa ☐ Iodine ☐ Latex

Pharmacy Name: _____

Pharmacy Phone Number: _____

List of Physicians, Specialty, Phone Number:

_____ _____

_____ _____

_____ _____

_____ _____

List of Medications:

_____ _____

_____ _____

_____ _____

_____ _____

List of Supplements:

_____ _____

_____ _____

_____ _____

_____ _____

Other Information We Should Know:

_____

In Case of Emergency – Name: _____ **Phone Number:** _____

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: _____ **Date:** _____

Dentist/Hygienist Signature: _____ **Date:** _____