

# MOUTHGUARD HEALTH HISTORY QUESTIONNAIRE

## Patient Information

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone# (\_\_\_\_\_) \_\_\_\_\_  
Emergency Contact Name \_\_\_\_\_ Phone # \_\_\_\_\_

## Patient Medical History

Physician's Name \_\_\_\_\_  
Name of Dentist \_\_\_\_\_ Date of Last Dental Exam \_\_\_\_\_  
Name of Orthodontist \_\_\_\_\_ Date of Last Dental Exam \_\_\_\_\_

Please circle the correct answers for each question below. Your answers are for our records only, and will be considered confidential. Additional questions concerning your health may be asked. Please detail any answers as completely as possible. Each answer can affect the oral care we provide.

1. Has there been any change in your general health with in the past year?.....Yes No  
If yes, please describe condition. \_\_\_\_\_
2. Have you been hospitalized during the past 5 years?.....Yes No  
If yes Please Explain \_\_\_\_\_
3. List ALL medications you currently take (Include vitamins, diet, herbal, prescription, and non-prescription supplements) \_\_\_\_\_
4. Allergies or Adverse Reactions. **Circle all that apply** (Describe Reaction)

Acetaminophen	Iodine	Seasonal
Aspirin	Latex	Sinus
Ibuprofen	Metal	Sulfa

Do you have or have you had any of the following? **Circle all that apply**

Abnormal wound healing	Diabetes	Mitral Valve Prolapse
AIDS/HIV	Easily Winded	Muscle Pain
Anemia	Eating Disorder	Neurological Disorder
Angina	Emphysema	Persistent Cough
Arthritis	Epilepsy/Convulsions	Productive Cough
Asthma	Esophageal Reflux	Radiation/chemo therapy
Bronchitis / Pneumonia	Fainting/Dizziness☐	Recent weight gain/loss
Cancer	Frequently Tired	Rheumatic Fever
Cardiac Pacemaker	Hay Fever/Allergies	STD
Chest Pains	Heart Murmur	Thyroid Problem
Cold Sores	Hepatitis/Jaundice	Tuberculosis
Depression	Leukemia	Tumor or Growth

Do you have any other medical conditions? Yes/No Please List \_\_\_\_\_

Are you required to take medication before dental treatment?.....Yes No  
Have you been surgically treated for periodontal disease?.....Yes No  
Have you been treated for Oral Surgery?.....Yes No  
Do you wear a dental appliance?.....Yes No

*I certify that I have read and understood the above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold Dr. Abraham, or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.*

Patient Signature (or Guardian) \_\_\_\_\_ Date \_\_\_\_\_