DEVON DENTAL ASSOCIATES
MEDICAL HEALTH QUESTIONAIRE

1. General Health (please check): ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR
2. Name and address of physician: _____
3. Last complete physical: _____
4. Has there been any change in your general health within the past year?.....YES NO
5. Are you now under the care of a physician?..... .....YES NO
   If so, what is the condition being treated? _____
6. Have you had any serious illness or operation in the past 5 years?.....YES NO
   If so, what was the illness or operation? _____
7. Have you been hospitalized for any serious illness within the past five (5) years?.....YES NO
   If so, what was the problem? _____
8. Do you use tobacco?.....YES NO
   If so, what type and what is your average daily usage? _____
9. Have you had any serious trouble associated with any previous dental treatment?.....YES NO
   If so, explain _____
   _____
10. Are you wearing contact lenses?.....YES NO

Do you have or have you had any of the following diseases or problems?: (Please check box)

☐ Damaged Heart Valve	☐ Cardiac Pacemaker	☐ Fainting Spells Or Seizures	☐ Fever Blisters
☐ Artificial Heart Valve	☐ Low Blood Pressure	☐ Diabetes	☐ Abnormal Or Prolonged
☐ Heart Murmur	☐ Stomach Ulcers	☐ Arthritis	Bleeding
☐ Mitral Valve Prolapse	☐ Hepatitis	☐ Inflammatory Rheumatism	☐ Anemia
☐ Congenital Heart Lesion	☐ Jaundice Or Liver Disease	☐ Hip Or Knee Replacement	☐ Cancer Or Tumor
☐ Cardiovascular Disease	☐ Kidney Problem	☐ AIDS Or HIV Positive Test	☐ Head And Neck Radiation In
☐ Heart Attack	☐ Allergies	☐ Tuberculosis	The Past 3 Years
☐ Angina	☐ Sinus Problem	☐ Persistent Cough	☐ Systemic Steroid Treatment
☐ Coronary Artery Disease	☐ Asthma	☐ Sexually Transmitted	
☐ High Blood Pressure	☐ Hayfever	Disease	
☐ Stroke	☐ Hives Or Skin Rash	☐ Herpes	

WOMEN:

1. Are you pregnant?..... YES NO
2. Do you have any problems associated with your menstrual period?.....YES NO
3. Are you nursing?.....YES NO
4. Are you taking oral contraceptives?.....YES NO

Please list any MEDICATION(S) (INCLUDING OVER-THE-COUNTER DRUGS) you currently take:

Medication	Dosage	For what purpose?	Medication	Dosage	For what purpose?

Please list any MEDICINE ALLERGIES AND REACTIONS you have had:

Medication	Reaction	Medication	Reaction

Do you have any disease, condition, or problem not listed above that you think I should know about.....YES NO
If so, explain _____

To the best of my knowledge the above questions have been accurately answered.

PATIENT NAME (print) _____ PATIENT SIGNATURE _____

DOCTOR'S NOTES

DATE / /

DOCTOR SIGNATURE _____