LOMA LINDA UNIVERSITY SCHOOL OF DENTISTRY
MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date: _____

1. Have you had any health problems in the **past five years?** .....☐yes ☐no
   If yes, please explain:
   _____

2. Have you seen a physician or other health care provider in the **past two years?**.....☐yes ☐no
   If yes, please answer the following:
   Physician's name: _____ Phone #: _____
   City: _____
   Date of last visit: _____
   Date of last physical evaluation: _____

3. Is there any activity your doctor says you cannot do? .....☐yes ☐no
   If yes, please explain:
   _____

4. Have you been hospitalized or had a serious illness in the past five years?.....☐yes ☐no
   If yes, please explain:
   _____

5. Do you have or have you ever had any heart disease? .....☐yes ☐no

6. Do you have or have you ever had high blood pressure? .....☐yes ☐no

7. Have you ever had a stroke/TIA? .....☐yes ☐no

8. Do you have or have you ever had a bleeding problem or any blood disorders? .....☐yes ☐no

9. Do you have or have you ever had any nervous or nervous system disorders? .....☐yes ☐no

10. Do you have or have you ever had any head and neck, eye, ear, nose or throat disorders? .....☐yes ☐no

11. Do you have or have you ever had any glandular/endocrine disorders? .....☐yes ☐no

12. Do you have or have you ever had any muscle, joint, skin or connective tissue disorders? .....☐yes ☐no

13. Do you have or have you ever had any respiratory (breathing) disorders? .....☐yes ☐no

14. Do you have or have you ever had any kidney/urinary tract/genital disorders? .....☐yes ☐no

15. Do you have or have you ever had any digestive system/liver disorders? .....☐yes ☐no

16. Do you have or have you ever had cancer? .....☐yes ☐no

17. Do you have any allergies? .....☐yes ☐no

18. Have you had any major surgeries? .....☐yes ☐no

19. Have you ever or are you currently taking prescription diet pills? .....☐yes ☐no

20. Do you use tobacco products? .....☐yes ☐no

21. Do you drink alcoholic beverages? .....☐yes ☐no

22. Have you ever or are you currently using recreational drugs? .....☐yes ☐no

23. Are you a recovering alcoholic or addict? .....☐yes ☐no

24. Do you have any other medical condition that you think we should know about? .....☐yes ☐no
If yes, please explain:

_____

25. Are you HIV Positive? .....☐yes ☐no

26. Are you currently taking or have you previously taken bisphosphonate medications, such as Actonel, Fosomax or Zometa within the past twelve years? .....☐yes ☐no

27. Are you taking (or supposed to be taking) any medicine, drugs or pills of any kind including over-the-counter, herbal and nutritional supplements? .....☐yes ☐no

FOR WOMEN ONLY

28. Are you pregnant or is there a possibility that you may be pregnant? .....☐yes ☐no

29. Are you breast feeding? .....☐yes ☐no

Permission is granted for students, staff and /or faculty to perform procedures necessary, including taking of photographs, radiographs (x-rays), conducting an examination and obtaining a medical consultation from my physician(s) in order to determine my dental treatment needs and clinical assignment. I understand that radiographs are an essential tool in evaluating my treatment needs. I also understand there is a minimal risk associated with exposure to dental radiation and that all appropriate precautions will be used to keep radiation exposure to a minimum. I understand that I have the right to refuse any procedure, but my refusal may result in termination of treatment.

To the best of my knowledge, all of the preceding answers are true and correct. If I have any change in my health, abnormal laboratory test results, or if my medicines change, I will inform the dentist at my next appointment.

_____ _____

Date Patient, Parent, or Guardian Signature