LSU Health NEW ORLEANS **School of Dentistry**

Medical-Dental Questionnaire

axiUm No. _____ Date: _____

Print Name:	Date of Birth:	Sex: M F	Height: ft in	Weight: lbs

Race:
❑ Native American/Alaskan ❑ Asian ❑ Black/African American ❑ Native Hawaiian/Pacific Islander ❑ White ❑ Other

Ethnicity:
❑ Hispanic or Latino ❑ Not Hispanic or Latino

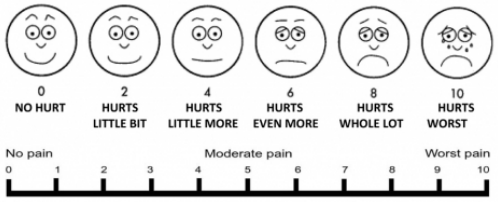
Address:	City, State, Zip:	Marital Status:	Occupation:
Daytime Phone #:	Home Phone #:	email address:	

In Case of Emergency, Contact:	Name:	Relationship:
Address:	City, State, Zip:	Phone:

DENTAL HISTORY

		Yes	No	Unsure
01	Are you presently having a toothache / dental pain?	☐	☐	☐

02 Please mark your current level of dental pain:



03 **Briefly explain your present dental problems or concerns:**

04	Do you bleed excessively after tooth extraction?	☐	☐	☐
05	Have you had pain or swelling MORE THAN two weeks after injury or surgery to the face or jaw?	☐	☐	☐
06	Any serious reactions to local or general anesthetics (ex: lidocaine, propofol), nitrous oxide?	☐	☐	☐
07	Have you ever had any serious trouble associated with any previous dental treatment?	☐	☐	☐
08	If yes, explain:			
09	Do you have any sores or bumps in your mouth?	☐	☐	☐
10	Do you clench or grind your teeth?	☐	☐	☐
11	Are any teeth sensitive to cold or sweets?	☐	☐	☐
12	Has a doctor told you to take antibiotics BEFORE having your teeth cleaned or dental treatment?	☐	☐	☐

MEDICAL HISTORY PART 1

		Yes	No	Unsure
01	Are you being treated by a medical doctor now? Date of last visit:_____	☐	☐	☐
02	Reason:			
03	Are you taking any medications at the present time?	☐	☐	☐
	List all:			
04	Have you ever taken medication to relieve anxiety or depression?	☐	☐	☐
05	Sensitive or allergic to any medication?	☐	☐	☐
	List:			
06	Have you ever been hospitalized or had any surgical operations?	☐	☐	☐
07	Ever had excessive bleeding from a cut or wound?	☐	☐	☐
08	Have you ever had cancer? If yes, what kind?_____	☐	☐	☐
09	Do you have pain in the chest upon exertion?	☐	☐	☐
10	Shortness of breath after mild exercise or exertion?	☐	☐	☐
11	Do your ankles swell every day?	☐	☐	☐
12	Do you bruise too easily?	☐	☐	☐
13	Any problems sleeping: trouble breathing, use extra pillows, snoring, sleep apnea, sore jaws on waking?	☐	☐	☐
14	Are you thirsty and/or hungry much of the time?	☐	☐	☐
15	Have you lost or gained weight (more than 10 lbs) in the last year? Reason:_____	☐	☐	☐
16	Do you have frequent infections?	☐	☐	☐
17	Has a doctor ever said you had infectious diseases (for example, HIV, hepatitis C, tuberculosis?)	☐	☐	☐
18	Do you have frequent headaches or migraines?	☐	☐	☐
19	Frequently consume alcoholic beverages? If yes, how many drinks per week? _____	☐	☐	☐
20	Do you currently or have you in the past used tobacco products (chew, cigarettes, cigars, pipe)?	☐	☐	☐
21	Are your vaccinations up-to-date?	☐	☐	☐

COMPLETE OTHER SIDE

Please check the appropriate box for any condition that you have now *or* have had in the past. Each line must have one box checked.

MEDICAL HISTORY PART 2

1. CARDIOVASCULAR

	Yes	No	Unsure
Congestive heart failure	☐	☐	☐
Heart attack or disease	☐	☐	☐
Angina pectoris or chest pain	☐	☐	☐
Acute coronary syndrome	☐	☐	☐
High blood pressure	☐	☐	☐
Stroke	☐	☐	☐
Aneurysm	☐	☐	☐
Artificial heart valve	☐	☐	☐
Heart transplant	☐	☐	☐
Congenital heart defect or lesion	☐	☐	☐
Irregular heart beat	☐	☐	☐
Heart pacemaker or defibrillator	☐	☐	☐
Heart murmur, rheumatic fever, MVP	☐	☐	☐
Other heart problems	☐	☐	☐

2. BLOOD/ONCOLOGY

	Yes	No	Unsure
Blood Transfusion	☐	☐	☐
Anemia	☐	☐	☐
Sickle cell disease	☐	☐	☐
Leukemia	☐	☐	☐
Hemophilia	☐	☐	☐
Tendency to bleed longer than normal	☐	☐	☐
Delayed healing	☐	☐	☐
Head and neck cancer	☐	☐	☐
Chemotherapy or radiation treatment	☐	☐	☐

3. ENDOCRINE

	Yes	No	Unsure
Diabetes (If yes, what type?)	☐	☐	☐
Thyroid disease	☐	☐	☐
Chronic steroid therapy	☐	☐	☐
Hormone replacement therapy (HRT)	☐	☐	☐

4. NEURAL/PSYCHIATRIC

	Yes	No	Unsure
Severe headaches, fainting, dizzy spells	☐	☐	☐
Epilepsy, seizures, or convulsions	☐	☐	☐
Vision problems, glaucoma, eye pain	☐	☐	☐
Earaches/ringing in ears/hearing loss	☐	☐	☐
Anxiety attacks	☐	☐	☐
Psychiatric treatment	☐	☐	☐
Dementia	☐	☐	☐
Depression	☐	☐	☐
Schizophrenia	☐	☐	☐
Bipolar	☐	☐	☐
Eating disorders (anorexia, bulimia)	☐	☐	☐
Sleep disorders	☐	☐	☐
Learning disorders	☐	☐	☐
Alcohol or drug abuse	☐	☐	☐

5. GASTROINTESTINAL

	Yes	No	Unsure
Gastritis/ulcers/reflux disease	☐	☐	☐
Ulcerative colitis	☐	☐	☐
Crohn's disease	☐	☐	☐
Pesistent diarrhea/constipation	☐	☐	☐
Hepatitis (If yes, what type?)	☐	☐	☐
Cirrhosis	☐	☐	☐
Yellow jaundice	☐	☐	☐
Other liver disease	☐	☐	☐

6. RESPIRATORY

	Yes	No	Unsure
COPD chronic bronchitis	☐	☐	☐
COPD emphysema	☐	☐	☐
Asthma	☐	☐	☐
Respiratory allergies	☐	☐	☐
Chronic cough	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis (TB)	☐	☐	☐
Breathing difficulties	☐	☐	☐
Flu-like symptoms now	☐	☐	☐

7. SKIN / MUCOSA / MUSCULOSKELETAL

	Yes	No	Unsure
Allergy to latex (rubber gloves)	☐	☐	☐
Skin rash, hives, itching	☐	☐	☐
Dark mole(s) or recent changes	☐	☐	☐
Melanoma	☐	☐	☐
Fibromyalgia	☐	☐	☐
Sore muscles and joints	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Artificial joint	☐	☐	☐
Osteoporosis	☐	☐	☐
Medicines for osteoporosis/bone cancer	☐	☐	☐
Intravenous (IV) bisphosphonates	☐	☐	☐

8. GENITOURINARY

	Yes	No	Unsure
Sexually transmitted disease (STDs): syphilis, gonorrhea, genital herpes, chlamydia, HIV+ / AIDS	☐	☐	☐
Kidney (renal) dialysis	☐	☐	☐
Other kidney disorder	☐	☐	☐
Urinate frequently	☐	☐	☐

9. ORAL / FACIAL PAIN

	Yes	No	Unsure
Dry mouth (xerostomia) or burning tongue	☐	☐	☐
Mouth ulcers or fungus (candidiasis)	☐	☐	☐
White/red/discolored areas in the mouth	☐	☐	☐
Nerve pain (neuralgias)	☐	☐	☐
Pain in facial muscles	☐	☐	☐
TMD or TMJ (jaw joint/muscle) pain, noise	☐	☐	☐

10. OTHER CONDITIONS

	Yes	No	Unsure
Autoimmune disorders (Lupus, Sjogren's...)	☐	☐	☐
Enlarged lymph node or gland	☐	☐	☐
Other organ or cell transplant	☐	☐	☐
Hyperbaric oxygen therapy	☐	☐	☐
Disease, condition, or allergy not listed?	☐	☐	☐

(Describe here:)

11. FEMALES

	Yes	No	Unsure
Are you nursing a child or infant now?	☐	☐	☐
Are you pregnant now?	☐	☐	☐
Do you plan to become pregnant soon?	☐	☐	☐
Did you have any complications during pregnancy? (If never pregnant, answer no)	☐	☐	☐
Do you have trouble with your period? (If you don't menstruate, answer no)	☐	☐	☐

COMPLETE OTHER SIDE

To the best of my knowledge all the answers on **both sides of this page** are true and correct. If I have a change in my health information, I will inform my dentist at my next appointment.

Signature of Patient (18 or older)/ Parent / Guardian_____Date_____