axiUm No. _____

LSU Health NEW ORLEANS **School of Dentistry**

# Medical-Dental Questionnaire

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

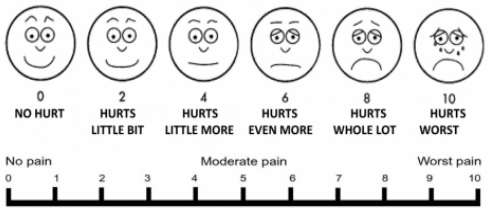
Military Service:
❑ None ❑ Active duty ❑ Retired

| Address: | City, State, Zip: | Apt # | 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

| | Yes | No | Unsure |
|---|---|---|---|
| **1. CARDIOVASCULAR** | | | |
| 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 | ☐ | ☐ | ☐ |
| High cholesterol/triglycerides | ☐ | ☐ | ☐ |
| Other heart problems | ☐ | ☐ | ☐ |
| **2. BLOOD/ONCOLOGY** | | | |
| 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** | | | |
| Diabetes (circle) Type 1 Type 2 | ☐ | ☐ | ☐ |
| Thyroid disease (circle) underactive overactive | ☐ | ☐ | ☐ |
| Chronic steroid therapy | ☐ | ☐ | ☐ |
| Hormone replacement therapy (HRT) | ☐ | ☐ | ☐ |
| **4. NEURAL/PSYCHIATRIC** | | | |
| Severe headaches, fainting, dizzy spells | ☐ | ☐ | ☐ |
| Epilepsy, seizures, or convulsions | ☐ | ☐ | ☐ |
| Vision problems, glaucoma, eye pain… | ☐ | ☐ | ☐ |
| Earaches/ringing in ears/hearing loss | ☐ | ☐ | ☐ |
| Anxiety (circle) mild mod sev panic | ☐ | ☐ | ☐ |
| Psychiatric treatment | ☐ | ☐ | ☐ |
| Dementia | ☐ | ☐ | ☐ |
| Depression | ☐ | ☐ | ☐ |
| Schizophrenia | ☐ | ☐ | ☐ |
| Bipolar | ☐ | ☐ | ☐ |
| Eating disorders (circle below) anorexia bulimia binge purge other | ☐ | ☐ | ☐ |
| Sleep disorders | ☐ | ☐ | ☐ |
| Learning disorders | ☐ | ☐ | ☐ |
| Alcohol or drug abuse | ☐ | ☐ | ☐ |
| **5. GASTROINTESTINAL** | | | |
| Indigestion (circle) gastritis ulcers reflux | ☐ | ☐ | ☐ |
| Ulcerative colitis | ☐ | ☐ | ☐ |
| Crohn's disease | ☐ | ☐ | ☐ |
| Pesistent diarrhea/constipation | ☐ | ☐ | ☐ |
| Hepatitis (circle) A B C D E | ☐ | ☐ | ☐ |
| Cirrhosis | ☐ | ☐ | ☐ |
| Yellow jaundice | ☐ | ☐ | ☐ |
| Other liver disease | ☐ | ☐ | ☐ |

| | Yes | No | Unsure |
|---|---|---|---|
| **6. RESPIRATORY** | | | |
| COPD chronic bronchitis | ☐ | ☐ | ☐ |
| COPD emphysema | ☐ | ☐ | ☐ |
| Asthma | ☐ | ☐ | ☐ |
| Respiratory allergies | ☐ | ☐ | ☐ |
| Chronic cough | ☐ | ☐ | ☐ |
| Sinus trouble | ☐ | ☐ | ☐ |
| Tuberculosis (TB) | ☐ | ☐ | ☐ |
| Breathing difficulty now (pneumonia, covid…) | ☐ | ☐ | ☐ |
| Flu-like/covid symptoms now | ☐ | ☐ | ☐ |
| **7. SKIN / MUCOSA / MUSCULOSKELETAL** | | | |
| Allergy to latex (rubber gloves) | ☐ | ☐ | ☐ |
| Skin rash, hives, itching | ☐ | ☐ | ☐ |
| Dark mole(s) or recent changes | ☐ | ☐ | ☐ |
| Melanoma | ☐ | ☐ | ☐ |
| Fibromyalgia | ☐ | ☐ | ☐ |
| Sore muscles and joints | ☐ | ☐ | ☐ |
| Arthritis (circle) osteoarthritis rheumatoid | ☐ | ☐ | ☐ |
| Artificial joint | ☐ | ☐ | ☐ |
| Osteoporosis | ☐ | ☐ | ☐ |
| Medicines for osteoporosis/bone cancer | ☐ | ☐ | ☐ |
| Intravenous (IV) bisphosphonates | ☐ | ☐ | ☐ |
| **8. GENITOURINARY** | | | |
| Sexually transmitted infections (circle below) HIV+/AIDS syphilis gonorrhea genital herpes chlamydia | ☐ | ☐ | ☐ |
| Kidney (renal) dialysis | ☐ | ☐ | ☐ |
| Other kidney disorder | ☐ | ☐ | ☐ |
| Urinate frequently | ☐ | ☐ | ☐ |
| **9. ORAL / FACIAL PAIN** | | | |
| 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** | | | |
| Autoimmune diseases (circle below) Lupus Frequent mouth ulcers Sjogrens Lichen planus Pemphigus/pemphigoid Other | ☐ | ☐ | ☐ |
| Enlarged lymph node or gland | ☐ | ☐ | ☐ |
| Organ or cell transplant | ☐ | ☐ | ☐ |
| Hyperbaric oxygen therapy | ☐ | ☐ | ☐ |
| Disease, condition, or allergy not listed? | ☐ | ☐ | ☐ |
| (Describe here:) | | | |
| | Yes | No | Unsure |
| **11. FEMALES** | | | |
| Are you nursing a child or infant now? | ☐ | ☐ | ☐ |
| Are you pregnant now? Due date: | ☐ | ☐ | ☐ |
| Do you plan to become pregnant soon? | ☐ | ☐ | ☐ |
| Any complications during pregnancy? (If never pregnant, 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_____