JAMES C. WEST, D.D.S., M.S.
MEDICAL HEALTH QUESTIONNAIRE

Name _____ Nickname _____ Birthdate _____
(Last) (First) (Middle)

Address _____ Gender ☐ Male ☐ Female
(Street) (City) (State) (Zip Code)

Physician or Pediatrician and Phone Number _____ _____

Do you have any history of, or conditions related to any of the following: [please check appropriate boxes]

☐ AIDS/HIV Positive	☐ Cold Sores	☐ Genital Herpes	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Anaphylaxis	☐ Congenital Heart Disease	☐ Growth Problems	☐ Jaw Pain	☐ Shingles
☐ Anemia	☐ Convulsions	☐ Headaches	☐ Kidney Problems	☐ Sickle Cell Anemia
☐ Angina	☐ Cortisone Meds	☐ Hearing/Vision	☐ Leukemia	☐ Sinus Trouble
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Attack	☐ Liver Disease	☐ Snoring
☐ Artificial Heart	☐ Dizziness	☐ Heart Disease	☐ Low Blood Pressure	☐ Sore Throats
☐ Artificial Joint	☐ Drug Addiction	☐ Heart Murmur	☐ Measles	☐ Spina Bifida
☐ Asthma	☐ Ear/Eyes/Nose	☐ Hemophilia	☐ Mitral Valve Prolapse	☐ Stroke
☐ Blood Disorder	☐ Easily Winded	☐ Hepatitis A	☐ Mononucleosis	☐ Swelling of Limbs
☐ Breathing Disorder	☐ Emphysema	☐ Hepatitis B or C	☐ Mumps	☐ Thyroid Disease
☐ Bruise Easily	☐ Epilepsy/Siezures	☐ Herpes	☐ Osteoporous	☐ Tonsilitis
☐ Cancer/Tumors	☐ Excessive Bleeding	☐ High Blood Pressure	☐ Parathyroid Disease	☐ Tuberculosis
☐ Cerebral Palsy	☐ Excessive Thirst	☐ High Cholesterol	☐ Psychiatric Care	☐ Ulcers
☐ Chemotherapy	☐ Fainting Spells	☐ Hives or Rash	☐ Radiation Treatment	☐ Venereal Disease
☐ Chest Pains	☐ Fever Blisters	☐ Hypoglycemia	☐ Recent Weight Loss	☐ Yellow Jaundice
☐ Chicken Pox	☐ Frequent Cough	☐ Immune Disorders	☐ Renal Dialysis	☐ Other
☐ Chronic Sinusitis	☐ Frequent Diarrhea	☐ Intestinal Disorders	☐ Rheumatic Fever	

Have you ever had any serious illness not listed above? ☐ Yes ☐ No _____

Current Height _____ Current Weight _____

Are you allergic to any of the following?

☐ Acrylic ☐ Aspirin ☐ Codeine ☐ Latex ☐ Local Anesthetic ☐ Penicillin ☐ Sulfa Drugs

☐ Other If yes please explain: _____

Are you under a physician's care? ☐ Yes ☐ No If yes, please explain: _____

Have you been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, please explain: _____

Do you take or have you taken Phen-Fen or Redux? ☐ Yes ☐ No If yes, please explain: _____

Have you ever taken Fosamex, Boniva Actinol or any other bisphosphonates? ☐ Yes ☐ No If yes, please explain: _____

Are you on a special diet? ☐ Yes ☐ No If yes, please explain: _____

Do you use tobacco? ☐ Yes ☐ No If yes, please explain: _____

Do you use controlled substances? ☐ Yes ☐ No If yes, please explain: _____

Female Patients: Are you

Pregnant/Trying to get pregnant? ☐ Yes ☐ No Taking Oral Contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Comments: _____

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I certify that I have read the questions and have accurately answered them. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. omissions that I may have made in the completion of this form. I also authorize Dr. West and any other member of his staff to complete an oral examination, dental prophylaxis necessary radiographs and apply topical fluoride.

Parent's/Guardian's Signature _____ Date _____