Franklin Medical
GROUP PC
56 Franklin Street, Waterbury, CT 06706

DENTAL HEALTH CENTER
MEDICAL HEALTH QUESTIONNAIRE

INSTRUCTIONS:
In the following questions, please check (☑) Yes or No; whichever applies. Your answers are for our records and will be kept confidential.

PATIENT'S NAME:

QUESTIONNAIRE COMPLETED BY:

RELATIONSHIP TO PATIENT:

DATE:

MEDICAL HISTORY			EXPLANATION
1. Is patient in good health? (If NO, Explain at right.)	❑ YES	❑ NO	
Explain a YES response to any of the following in the area at the right:			
2. Has there been any change in patient's general health in the past year:	❑ YES	❑ NO	
3. Patient's last physical examination was on _____	❑ YES	❑ NO	
4. Is patient now under the care of a physician?	❑ YES	❑ NO	
5. Print physician's name and address on right.			
6. Has patient had any operations?	❑ YES	❑ NO	
7. Has patient been hospitalized or had a serious illness within the past five years?	❑ YES	❑ NO	
8. Does patient have or has patient had any of the following diseases or problems:	❑ YES	❑ NO	
a. Cardiovascular disease (i.e., heart trouble, heart attack, coronary insufficiency, coronary occlusion, arteriosclerosis, angina, mitral valve prolapse, heart murmur)	❑ YES	❑ NO	
b. Rheumatic fever - Is premed needed? ❑ Yes ❑ No	❑ YES	❑ NO	
c. High blood pressure	❑ YES	❑ NO	
d. Bleeding or clotting disorder	❑ YES	❑ NO	
e. Fainting spells or seizures (Epilepsy)	❑ YES	❑ NO	
f. Diabetes	❑ YES	❑ NO	
g. Asthma or breathing problems	❑ YES	❑ NO	
h. Tuberculosis	❑ YES	❑ NO	
i. Hepatitis, juandice or liver disease	❑ YES	❑ NO	
j. Arthritis	❑ YES	❑ NO	
k. Ulcers or stomach problems	❑ YES	❑ NO	
l. Kidney problems	❑ YES	❑ NO	
m. Sexually Transmitted Disease	❑ YES	❑ NO	
n. Autoimmune Disease	❑ YES	❑ NO	
s. Other (specify)	❑ YES	❑ NO	
9. Has patient has abnormal bleeding associated with previous extractions, surgery or trauma?	❑ YES	❑ NO	
10. Has patient ever had a blood transfusion? If yes, when? _____	❑ YES	❑ NO	
11. Has patient had any surgery or radiation/chemotherapy for a tumor?	❑ YES	❑ NO	

OVER PLEASE - CONTINUED ON BACK

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PATIENT'S NAME:

QUESTIONNAIRE COMPLETED BY:

DENTAL HEALTH CENTER
MEDICAL HEALTH QUESTIONNAIRE (CONTINUED)

Explain a YES response to any of the following in the area at the right:

MEDICAL HISTORY			ITEM #	EXPLANATION
12. Is patient on drugs or medications?	❑ YES	❑ NO		
If so, please ☑:				
a. ❑ antibiotics g. ❑ insulin				
b. ❑ medicine for blood pressure h. ❑ cortisone				
c. ❑ aspirin i. ❑ antihistamines				
d. ❑ nitroglycerine j. ❑ tranquilizers				
e. ❑ blood thinner k. ❑ other (specify): _____				
f. ❑ digitalis				
13. Is patient allergic or has reacted adversely to any drugs or medications?	❑ YES	❑ NO		
If so, please ☑:				
a. ❑ local anesthetic g. ❑ codeine				
b. ❑ aspirin h. ❑ barbiturate				
c. ❑ penicillin i. ❑ other medication (specify): _____				
d. ❑ other antibiotic (specify): _____				
14. Has patient ever had joint replacement surgery?	❑ YES	❑ NO		
15. Does patient have any disease, condition or problem not listed above?	❑ YES	❑ NO		
WOMEN				
16. Are you pregnant?	❑ YES	❑ NO		
17. Are you on birth control pills?	❑ YES	❑ NO		
18. Are you nursing?	❑ YES	❑ NO		
19. Do you have any problems associated with your menstrual period?	❑ YES	❑ NO		

FAMILY AND SOCIAL HISTORY

1. Do you smoke? ❑ Cigarettes ❑ Cigar ❑ Pipe How much? _____
2. Do you consume alcoholic beverages mores than 3 times per week? ❑ YES ❑ NO
3. Do you now or have ever used "street" drugs? ❑ YES ❑ NO
4. Is there a family history of diabetes? ❑ YES ❑ NO ❑ DON'T KNOW
5. Are there any other problems about your health that you wish to inform us of?

PATIENT'S SIGNATURE: DATE:

RISK ASSESSMENT: ASA 1 2 3 4	
COMMENTS:	
RESIDENT'S SIGNATURE: DATE:	ATTENDING SIGNATURE: DATE: