PHILIP B. SALLBERG, DDS P.A.
Dental Clinic
MEDICAL AND DENTAL INFORMATION QUESTIONNAIRE

Patient Name:_____
(Last, First, MI)
Date of Birth:__/__/__ Patient Phone:_____
Social Security Number:_____

Reason for visit:_____ Pharmacy Used:_____

MEDICAL INFORMATION

If **"YES"** to any of the following items or if you are unsure, please explain in the space on the reverse side.

YES NO **1. Has there been any change in your general health within the past year?**

2. Your last physical examination was on:_____

3. Name, address, phone # of physician?_____
_____

YES NO **4. Are you now under the care of a Physician?**

YES NO **5. Have you been hospitalized for any surgical operation or serious illness? If so, please describe. _____**
_____

6. Do you have or have you had any of the following cardiovascular conditions?

YES NO a: Rheumatic fever, Rheumatic heart disease
YES NO b: Heart Murmur
YES NO c: Congenital Heart Defect
YES NO d: Vascular disease
YES NO e: Heart surgery/ Angioplasty
YES NO f: Vascular surgery
YES NO g: Infective endocarditis
YES NO h: Mitral valve prolapse
YES NO i: Pacemaker
YES NO j: Prosthetic heart valve
YES NO k: High blood pressure
YES NO l: Stroke
YES NO m: Heart attack (Heart trouble)
YES NO n: Angina
YES NO o: Heart Transplant
YES NO p: Other cardiovascular problems:
_____

Other Conditions?

YES NO q: Diabetes Mellitus
YES NO r: Hepatitis
YES NO s: Thyroid problems
YES NO t: Orthopedic pins, rods, screws
YES NO u: Joint Replacement
YES NO v: Prosthetic devices or implants: Type:_____
YES NO w: Hemophilia (blood disorders)
YES NO x:Tuberculosis
YES NO y: HIV infection
YES NO z: AIDS
YES NO aa: Glaucoma

7. Are you ALLERGIC to, or have you had any reactions to :

YES NO a. Local anesthetic (novocaine)
YES NO b. Penicillin, other antibiotics
YES NO c. Sulfa drugs
YES NO d. Aspirin or other medications
YES NO e. Latex

8. Do you have any other disease, allergies, or problems not listed above that I should know about? _____
_____

9. Are you taking, or have you taken any of the following:

YES NO a: Anticoagulants (blood thinners)
YES NO b: Blood Pressure Medication
YES NO c: Fosamax (Bisphosphates)

10: Medications being taking now- please list:
_____
_____
_____

11. WOMEN- Yes or NO: Are you pregnant?

12. Date of last dental treatment:_____
13. Date of last dental cleaning:_____

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS COMPLETE AND CORRECT.

_____ _____
Signature- Patient (or parent/guardian if patient is under 18) Date