



Lorène Boisvert, D.D.S.
Aesthetic and General Dentistry
Adults and Children

Medical Questionnaire

Surname _____ First Name _____
Address _____ City _____ State ____ Zip code _____
Home phone _____ Work phone _____ Cell phone _____
Birth date ____/____/____ Gender: M F Height _____ Weight _____ Marital status: S M D W
Social Security Number _____ - _____ - _____ E-mail _____
Employer _____ Profession _____
Emergency contact _____ Phone _____

For the following questions, please circle which answer applies. If you do not know the answer, circle the “?”. Your answers are for our records only and will be kept confidential in accordance with applicable laws. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Dental information

Yes No ? Do your gums bleed when you brush?
Yes No ? Are your teeth sensitive to hot, cold, sweets, or pressure?
Yes No ? Have you had any periodontal (gum) treatments?
Yes No ? Have you ever had orthodontic (braces) treatment?
Yes No ? Do you wear removable dental appliances?
Yes No ? Have you had a serious/difficult problem associated with any previous dental treatment? If so, please explain _____

How would you describe your current dental condition? _____
Date of your last dental exam _____ Date of your last dental x-rays _____
Was any treatment done at that time? If so, what treatment? _____
Are you happy with the appearance of your teeth? _____

Medical Information

Yes No ? Are you in good health?
Yes No ? Has there been any change in your general health within the past year?
Name of physician _____
City _____ Phone number _____
Yes No ? Are you currently under the care of a physician for a specific condition?
If so, what condition(s)? _____
Yes No ? Have you had any serious illness, operation, or been hospitalized in the past five years? If so, explain _____
Yes No ? Are you taking or have you recently taken any medicine(s), including non-prescription medicine? If so, what medicine(s) are you taking?
Prescribed _____
Over the counter _____
Natural or herbal preparations _____
Yes No ? Are you taking or have you taken any diet drugs such as Pondimin (fendluramine) Redux (dexphenfluramine) or phen-fen (phentermine)?
Yes No ? Do you wear contact lenses?
Yes No ? Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?
If so, when was the operation done? _____
Yes No ? Have you had any complications or difficulties with your prosthetic joint?
Yes No ? Has a physician or a previous dentist ever recommended that you take antibiotics prior to your dental treatment?

Allergies: Are you allergic to or have you had an allergic reaction to any of the following:

Yes	No	?	Local anesthetics	Yes	No	?	Latex
Yes	No	?	Penicillin or other antibiotics	Yes	No	?	Iodine
Yes	No	?	Aspirin	Yes	No	?	Pollen
Yes	No	?	Codeine or other narcotics	Yes	No	?	Animals
Yes	No	?	Barbiturates, sedatives, sleeping pills	Yes	No	?	Foods _____
Yes	No	?	Sulfa drugs	Yes	No	?	Other _____

For female patients:

Yes No ? Are you pregnant?
Yes No ? Are you nursing?
Yes No ? Are you taking birth control pills?

Please circle if you have or had any of the following:

Yes	No	?	Abnormal bleeding	Yes	No	?	Dry mouth
Yes	No	?	HIV or AIDS	Yes	No	?	Arthritis
Yes	No	?	Anemia	Yes	No	?	Asthma
Yes	No	?	G.E. reflux	Yes	No	?	Glaucoma
Yes	No	?	Hepatitis, jaundice	Yes	No	?	Hemophilia
Yes	No	?	Diabetes- If so, Type I or Type II	Yes	No	?	Low blood pressure
Yes	No	?	Osteoporosis	Yes	No	?	STD
Yes	No	?	Headaches, migraines	Yes	No	?	Tuberculosis
Yes	No	?	Neurological disorders	Yes	No	?	Sinus problems
Yes	No	?	Stroke	Yes	No	?	Ulcer
Yes	No	?	Mental health disorders	Yes	No	?	Sleep disorder
Yes	No	?	Blood transfusion				
			If so, when: _____				
Yes	No	?	Cancer/chemotherapy/radiation				
			If so, when: _____				
Yes	No	?	Cardiovascular diseases:				
			-Angina				-High blood pressure
			-Arteriosclerosis				-Artificial heart valves
			-Mitral valve prolapse				-Damaged heart valves
-			-Coronary occlusion				-Heart attack
			-Heart murmur				-Congenital heart defects
			-Pacemaker				-Rheumatic heart disease
Yes	No	?	Eating disorder - if so, specify _____				
Yes	No	?	Recurrent infections - if so, specify _____				
Yes	No	?	Severe or rapid weight loss				
Yes	No	?	Epilepsy				
Yes	No	?	Fainting spells or seizures				
Yes	No	?	Sores or ulcers in the mouth				
Yes	No	?	Persistent swollen glands in neck				
Yes	No	?	Do you have any disease, condition, or problem not listed above that you think we should know about?				

I certify that I have read and that I understand the above. I will not hold my dentist, or any other member of his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of patient or legal guardian: _____ **Date** _____