MEDICAL/HEALTH QUESTIONNAIRE

Mark R. Zemanovich, D.D.S., P.C.

The following information is confidential and for our records only.

Today's Date: _____/______/______

Patient's Name: ____ **Birth Date:** ____/_____/____

Gender: **Male** ☐ **Female** ☐ **Age:** ______ **Height:** ________ **Weight:** _________

Occupation: _________________________ **Single** ☐ **Married** ☐ **Spouse's Name:** _____________

Emergency Contact: __________________________________ **Phone:** (_______)________-__________

Primary Physician: ___________________________________ **Phone:** (_______)________-__________

Other Physician: _____________________________________ **Phone:** (_______)________-__________

Last Physical Exam: _____________________ **Results:** ____

Referring Dentist: ___________________________________ **Phone:** (_______)________-_________

Reason for your visit: ____

On the following questions, please circle the correct answer and provide comment on all yes answers.

Question			
1. Are you experiencing pain from your mouth at this time?	NO	YES	Where? ________________________
2. Have you ever had periodontal (gum) treatment? When?_________ Doctor?________________	NO	YES	For What?______________________
3. Have any relatives lost all of their teeth?	NO	YES	
4. Have you had swollen areas on your gums or abscesses?	NO	YES	When? _________________________
5. Do your gums bleed?	NO	YES	
6. Have you noticed bad odors or taste?	NO	YES	Which? ________________________
7. Do you frequently have fever blisters, ulcers, or sores in your mouth or on your lips?	NO	YES	Which? ________________________
8. Do you have any teeth sensitive to heat, cold, or sweets?	NO	YES	Which? ________________________
9. Do you have any teeth tender to biting or pressure?	NO	YES	Which? ________________________
10. Do you have any loose teeth?	NO	YES	
11. Have you noticed your teeth moving lately or separating?	NO	YES	
12. Have you ever worn braces?	NO	YES	
13. Are you dissatisfied with the appearance of your teeth?	NO	YES	Why? __________________________
14. Do you brush your teeth at least once a day?	NO	YES	How many times? _______________
15. Do you use a mechanical or manual toothbrush?	NO	YES	Which? ________________________
16. Do you use floss, toothpicks, or other dental aids?	NO	YES	Which? ________________________

REVIEW OF SYSTEMS (ROS)

1. Are you in good health? NO YES

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

3. Are you under the care of a physician? NO YES

4. Do you have any history of heart problems? NO YES

Y N
- ☐ ☐ Hypertension?____________________________
- ☐ ☐ Heart Murmur, MVP?______________________
- ☐ ☐ Arrhythmia? ____________________________
- ☐ ☐ Congenital Defect? ______________________
- ☐ ☐ Heart Attack? ___________________________
- ☐ ☐ Stroke? _______________________________
- ☐ ☐ Pacemaker? ____________________________
- ☐ ☐ Rheumatic Fever? _______________________
- ☐ ☐ Other? ________________________________

5. Do you have chest pain upon exertion? NO YES

Rating? ☐ I ☐ II ☐ III ☐ IV

6. Do you have swollen ankles? NO YES

7. Do you have any breathing problems? NO YES

Y N
- ☐ ☐ Shortness of breath? ______________________
- ☐ ☐ Asthma? ______________________________
- ☐ ☐ COPD? _______________________________
- ☐ ☐ Seasonal Allergies? _______________________
- ☐ ☐ Sinusitis? _____________________________
- ☐ ☐ Other? ________________________________

8. Do you have any gastrointestinal problems? NO YES

Y N
- ☐ ☐ GERD or Ulcers? _________________________
- ☐ ☐ Crohns Disease? _________________________
- ☐ ☐ Other? ________________________________

9. Do you have any liver problems? NO YES

Y N
- ☐ ☐ Hepatitis? _____________________________
- ☐ ☐ Jaundice? _____________________________
- ☐ ☐ Other? ________________________________

10. Do you have any kidney problems? NO YES

Y N
- ☐ ☐ Frequent urination? ______________________
- ☐ ☐ Other? ________________________________

11. Do you have or have you had Tuberculosis? NO YES

12. Do you have any genitourinary problems? NO YES

Y N
- ☐ ☐ Venereal disease? ______________________
- ☐ ☐ Other? ________________________________

13. Do you have any blood/ bleeding disorders? NO YES

Y N
- ☐ ☐ Anemia? ______________________________
- ☐ ☐ Hemophilia? ___________________________
- ☐ ☐ Von Willebrand's? ______________________
- ☐ ☐ Anticoagulants? ________________________

  Recent INR?___________ Date? __________
- ☐ ☐ Other? ________________________________

14. Do you have any history of diabetes? NO YES

Type? ☐ Type 1 ☐ Type 2

Y N
- ☐ ☐ Relatives with diabetes? __________________
- ☐ ☐ Do you check your blood sugar?

  How often? ___________ Last time? ________

  Recent BS? ___________ HbA1c? _________

15. Do you have a history of fainting? NO YES

When? _____________ Why? ____________

16. Do you have a history of seizures/epilepsy? NO YES

Type? ☐ Grand Mal ☐ Petite Mal ☐ Epilepticus

How often? _______________ Last ? ______________

How long? ________________ Aura? ______________

17. Do you have a history of headaches? NO YES

How often? _______________ Where? _____________

18. Do you have any joint pains or arthritis? NO YES

Where? __________________ When? ______________

19. Do you have any vision problems? NO YES

What? ____

20. Do you have any other sensory problems? NO YES

What? ____

21. Do you have any psychological problems? NO YES

What? ____

22. Do you have HIV/AIDS? NO YES

Viral load? _______ T-Cell? _______ Date?________

23. Do you have thyroid or adrenal problems? NO YES

What? ____

24. **Do you have or have you had cancer?** NO YES

When? _________________ Where? _______________

Radiation? ______________________________________

25. **Do you bruise easily?** NO YES

26. **If you cut yourself does it stop bleeding?** NO YES

What happens? __________________________________

27. **Have you broken any bones?** NO YES

Which? _________________ How? ________________

28. **Do you have problems healing?** NO YES

What? ____

29. **Do you have any rashes or skin problems?** NO YES

What? ____

30. **Do you smoke?** NO YES

How much? _____________ How longs? ____________

31. **Do you use smokeless tobacco?** NO YES

32. **Do you drink alcohol?** NO YES

How much? _____________ How often? _____________

33. **Do you use/ have a history of any drug use?** NO YES

What? __________________ When? ________________

34. **Are you on a diet?** NO YES

35. **Do you exercise?** NO YES

What? __________________ How often? _____________

36. **Are you pregnant?** NO YES

Trimester? ______________ Due date? ______________

37. **Are you taking birth control pills?** NO YES

38. **Any other medical concerns?** NO YES

What? ____

ALLERGIES

1. **Are you allergic to any medications?** NO YES

What? ______________________ Rxn? _______________

What? ______________________ Rxn? _______________

What? ______________________ Rxn? _______________

What? ______________________ Rxn? _______________

2. **Do you have any other allergies?** NO YES

What? ______________________ Rxn? _______________

What? ______________________ Rxn? _______________

MEDICATIONS

1. **Do you take any prescribed medications?** NO YES

Rx? ______________________________ Dose? _______

Rx? ______________________________ Dose? _______

Rx? ______________________________ Dose? _______

Rx? ______________________________ Dose? _______

Rx? ______________________________ Dose? _______

Rx? ______________________________ Dose? _______

Rx? ______________________________ Dose? _______

2. **Do you take any OTC medications?** NO YES

What? ____________________________ Dose? _______

What? ____________________________ Dose? _______

What? ____________________________ Dose? _______

3. **Do you take any herbal supplements?** NO YES

What? ____________________________ Dose? _______

What? ____________________________ Dose? _______

4. **Do you take vitamins?** NO YES

What? ____________________________ Dose? _______

What? ____________________________ Dose? _______

HOSPITALIZATIONS

1. **Have you ever been hospitalized?** NO YES

When? ____________ Why? ______________________

When? ____________ Why? ______________________

When? ____________ Why? ______________________

When? ____________ Why? ______________________

When? ____________ Why? ______________________

2. **Where there any complications with your hospitalizations?** NO YES

What? ____

To the best of my knowledge, all of the above answers are true and correct. If I ever have any changes in my medical history, I will inform Dr. Zemanovich at the next appointment.

______________________________ ____________
Patient's Signature Date

______________________________ ____________
Doctor's Signature Date