# Medical History Questionnaire

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|---|---|
| Name: | Date of Birth: M/ D/ Y/ |
| Home Address: | Age: Sex: M / F |
| | Nationality: |
| Business/Occupation: | Home Telephone: |
| | Office Telephone: |
| Who referred you to Dr. Hasebe ? | |

**In preparation for your dental exam, please answer the following questions. Your privacy will be respected. Please circle the responses that apply to you.**

1. **Have you ever had:**
   Cardiac Disease ・ Hypertension ・ Hypotension ・ Tuberculosis
   Blood Disease/Anemia ・ Allergies ・ Liver Disease(Hepatitis ・Jaundice)
   Kidney Disease (Dialysis Y/N)・ Gastric Ulcer ・ Diabetes
   Aside from the above sickness, conditions and etc., please write any other medical concerns that you have. Other( )

2. **Are you presently seeing any other doctors?** **YES / NO**
   If yes, please write the name of the doctor or hospital and reason.
   ( )

3. **Are you presently taking any medications?** **YES / NO**
   If **yes**, which types? ( )
   **Do you have any sensitivities to any medication?** **YES / NO**
   If **yes**, which ones? ( )

4. **Have you ever been treated with anesthesia (local/general) by a dentist?** **YES / NO**
   **While under anesthesia, did you have an adverse reaction?** **YES / NO**
   **Was the anesthesia successful?** **YES / NO**
   **Do you have a history of blood clotting problems?** **YES / NO**
   **Is there anyone in your family who has a history of blood clotting problems?** **YES / NO**

5. **If you are a woman, please answer the following:**
   **Are you pregnant?** If **yes**, how many months? ( months) **YES / NO**
   **Do you have regular menstruation?** **YES / NO**
   **How many months post-partum are you?** ( months)

6. **Are you presently taking any specific precautions for your physical health?**

7. **Do you have any comments or suggestions on your treatment at HASEBE DENTAL CLINIC?**

Thank you!

HASEBE DENTAL CLINIC