



Jaws Family Dentistry
Dr Yaw Ahyia-Osae
Contact: 061 526-5146
20 Greenwood Str
Berea, East London
5241

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Medical Questionnaire

Where did you hear about us?

Name & Surname:

ID Number:

1. Google search
2. Friend/ family/doctor
3. Facebook
4. Tik-tok
5. Instagram
6. Signage (Board)

1. Have there been any changes in your health in the past year?	Y	N
2. Are you under the care of a physician?	Y	N
3. Have you had any serious illnesses or operations?	Y	N
4. Have you ever taken weight-loss medication?	Y	N
5. Females: Are you pregnant?	Y	N

Explain any 'yes' answers: _____

6. Please check if you have (or have had) any of the following problems:

- | | | |
|--|--|---|
| <input type="checkbox"/> AIDS / HIV Positive | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart, any problems | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Arthritis | Describe _____ | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Artificial heart valve(s) | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Skin rash |
| <input type="checkbox"/> Artificial joint(s) | <input type="checkbox"/> Herpes | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis A B C D | <input type="checkbox"/> Surgical implants |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Swelling, feet or ankles |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Tuberculosis |
| Describe _____ | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Ulcers/colitis/acid reflux |
| <input type="checkbox"/> Chemo/radiation therapy | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Vision Impairment |
| <input type="checkbox"/> Circulation problems | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Other |
| <input type="checkbox"/> Cortisone treatments | <input type="checkbox"/> Mitral valve prolapse | Describe _____ |
| <input type="checkbox"/> Cough, persistent or bloody | <input type="checkbox"/> Nervous problems | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> NONE OF THESE |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Psychiatric care | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Respiratory disease | |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Rheumatic fever | |
| <input type="checkbox"/> Food allergies | <input type="checkbox"/> Seizure disorders | |
| <input type="checkbox"/> Headaches, frequent/severe | | |
| <input type="checkbox"/> Hearing loss | | |

7. Allergies/Sensitivity:

- Anesthetic
- Aspirin
- Penicillin
- Codeine
- Sulfa
- Iodine
- Latex
- Nickel
- Other _____
- NONE OF THESE**

8. List any medications (prescription, non-prescription, and/or vitamins) you are currently taking:

9. Pre-medication required before dental treatment? Y N

Prescribing Physician _____

Dosage/Time taken _____

10. Travel within last 30 days? Y N

If yes, where: _____

Signature..... Date.....