Medical History Questionnaire

OFFICE USE
Patient ID: _____

NAME: _____
First *Middle Initial* *Last*

FORM DATE: __/__/____

DATE OF BIRTH: _____

This questionnaire was designed to provide important facts regardng the history of your pain or condition. The information you provide will assist in reaching a diagnosis and determining the source of your problem. Please take your time and answer each question as completely and honestly as possible. Please sign each page.

LIST ANY MEDICATIONS/SUBSTANCES WHICH HAVE CAUSED AN ALLERGIC REACTION:

Y ☐ N ☐	Antibiotics	Y ☐ N ☐	Latex	Y ☐ N ☐	Sedatives
Y ☐ N ☐	Aspirin	Y ☐ N ☐	Local anesthetics	Y ☐ N ☐	Sleeping pills
Y ☐ N ☐	Barbiturates	Y ☐ N ☐	Metals	Y ☐ N ☐	Sulfa drugs
Y ☐ N ☐	Codeine	Y ☐ N ☐	Penicillin		
Y ☐ N ☐	Iodine	Y ☐ N ☐	Plastic		

Other _____ _____ _____

LIST ANY MEDICATIONS CURRENTLY BEING TAKEN:

Medication name	Dosage/ Frequency	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other Items: _____ _____

MEDICAL HISTORY: (Please indicate dates on items marked past)

Medical condition	Never	Current	Past	If past, enter date
Acid reflux	☐	☐	☐	_____
Adenoids Removed	☐	☐	☐	_____
Anemia	☐	☐	☐	_____
Arteriosclerosis	☐	☐	☐	_____
Arthritis	☐	☐	☐	_____
Asthma	☐	☐	☐	_____
Autoimmune disorder	☐	☐	☐	_____
Bleeding easily	☐	☐	☐	_____
Blood pressure - High	☐	☐	☐	_____
Blood pressure - Low	☐	☐	☐	_____
Bruising easily	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Chemotherapy	☐	☐	☐	_____
Chronic cough	☐	☐	☐	_____
Chronic fatigue	☐	☐	☐	_____
Chronic pain	☐	☐	☐	_____
Cold hands and feet	☐	☐	☐	_____
COPD	☐	☐	☐	_____
Current pregnancy	☐	☐	☐	_____
Depression	☐	☐	☐	_____

Medical condition	Never	Current	Past	If past, enter date
Injury to teeth	☐	☐	☐	_____
Insomnia	☐	☐	☐	_____
Intestinal disorders	☐	☐	☐	_____
Jaw joint surgery	☐	☐	☐	_____
Kidney problems	☐	☐	☐	_____
Liver disease	☐	☐	☐	_____
Meniere's disease	☐	☐	☐	_____
Menstrual cramps	☐	☐	☐	_____
Multiple sclerosis	☐	☐	☐	_____
Muscle aches	☐	☐	☐	_____
Muscle shaking (tremors)	☐	☐	☐	_____
Muscle spasms or cramps	☐	☐	☐	_____
Muscular dystrophy	☐	☐	☐	_____
Nasal allergies	☐	☐	☐	_____
Needing extra pillows to help breathing at night	☐	☐	☐	_____
Nervous system irritability	☐	☐	☐	_____
Nervousness	☐	☐	☐	_____
Neuralgia	☐	☐	☐	_____
Numbness of fingers	☐	☐	☐	_____

Patient Signature _____ Date _____

Medical condition	Never	Current	Past	If past, enter date
Diabetes				
Difficulty concentrating				
Difficulty sleeping				
Dizziness				
Emphysema				
Epilepsy				
Excessive thirst				
Fibromyalgia				
Fluid retention				
Frequent cough				
Frequent illnesses				
Frequent stressful situations				
Glaucoma				
Gout				
Hay fever				
Hearing impaired				
Heart attack				
Heart disorder				
Heart murmur				
Heart pacemaker				
Heart palpitations				
Heart valve replacement				
Hemophilia				
Hepatitis				
Hypertension				
Hypoglycemia				
Immune system disorder				
Injury to face				
Injury to mouth				
Injury to neck				

Medical condition	Never	Current	Past	If past, enter date
Osteoarthritis				
Osteoporosis				
Ovarian cysts				
Parkinson's disease				
Poor circulation				
Prior orthodontic treatment				
Psychiatric care				
Radiation treatment				
Rheumatic fever				
Rheumatoid arthritis				
Scarlet fever				
Scoliosis				
Shortness of breath				
Sinus problems				
Skin disorder				
Sleep apnea				
Slow healing sores				
Speech difficulties				
Stroke				
Swelling in ankles or feet				
Swollen, stiff or painful joints				
Tendency for ear infections				
Tendency for frequent colds				
Tendency for sore throats				
Thyroid disorder				
Tired muscles				
Tonsils Removed				
Tuberculosis				
Tumors				
Urinary disorders				
Wisdom teeth (third molar) extraction				

Other	Current	Past	If past, enter date

Other	Current	Past	If past, enter date

ADDITIONAL MEDICAL HISTORY ITEMS:

	Never	Current	Past	If past, enter date
Recreational drugs				

	Never	Current	Past	If past, enter date
HIV/AIDS				

LIST ANY SURGICAL OPERATIONS YOU HAVE HAD:

Y	N	Appendectomy	Y	N	Heart	Y	N	Thyroid
Y	N	Back	Y	N	Hernia repair	Y	N	Tonsillectomy
Y	N	Ear	Y	N	Lung	Y	N	Uvulectomy
Y	N	Gallbladder	Y	N	Nasal	Y	N	Periodontal

Other _____ _____ _____

_____ _____ _____

Patient Signature _____ Date _____

FAMILY HISTORY Has any member of you family had (parent, sibling or grandparent):

__Yes __No Cancer
__Yes __No Heart disease
__Yes __No Diabetes
__Yes __No High blood pressure
__Yes __No Stroke
__Yes __No Sleep disorder
__Yes __No Obesity
__Yes __No Thyroid disorder
__Yes __No Father snores
__Yes __No Mother snores
__Yes __No Father has sleep apnea
__Yes __No Mother has sleep apnea

SOCIAL HISTORY:

Patient's Occupation _____ Employer _____

Tobacco Use: Cigarettes ☐ Never smoked ☐ Current smoker # packs per day ____ # of years ____ ☐ Quit When did you quit? _____

Other tobacco: ☐ Pipe ☐ Snuff ☐ Cigar ☐ Chew

Alcohol Use: Do you drink alcohol? ☐ Yes ☐ No If yes, # of drinks per week: ____

Caffeine Intake: ☐ None ☐ Coffee/Tea/Soda # cups per day: ____

Additional:

__Yes __No Regular exercise

I authorize the release of a full report of examination findings, diagnosis, treatment program etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all charges for treatment to me regardless of insurance coverage.

Patient Signature _____ Date _____

I certify that the medical history information is complete and accurate.

Patient Signature _____ Date _____