Medical History Questionnaire

OFFICE USE
Patient ID: _____

NAME: _____
First *Middle Initial* *Last*

FORM DATE: __/__/____

DATE OF BIRTH: _____

Address: _____

Phone Number: _____ Email: _____

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

Y ☐ N ☐	No known allergens	Y ☐ N ☐	Iodine	Y ☐ N ☐	Plastic
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		

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	☐	☐	☐	_____
Arthritis	☐	☐	☐	_____
Asthma	☐	☐	☐	_____
Autoimmune disorder	☐	☐	☐	_____
Arteriosclerosis	☐	☐	☐	_____
Bleeding easily	☐	☐	☐	_____
Blood pressure - High	☐	☐	☐	_____
Blood pressure - Low	☐	☐	☐	_____
Bruising easily	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Chemotherapy	☐	☐	☐	_____
Chronic cough	☐	☐	☐	_____
Chronic fatigue	☐	☐	☐	_____
Chronic pain	☐	☐	☐	_____
Chronic sinus problems	☐	☐	☐	_____
COPD	☐	☐	☐	_____
Cold hands and feet	☐	☐	☐	_____
CPAP	☐	☐	☐	_____

Medical condition	Never	Current	Past	If past, enter date
Insomnia	☐	☐	☐	_____
Intestinal disorders	☐	☐	☐	_____
Irregular heartbeat	☐	☐	☐	_____
Jaw joint surgery	☐	☐	☐	_____
Kidney problems	☐	☐	☐	_____
Liver disease	☐	☐	☐	_____
Low energy	☐	☐	☐	_____
Meniere's disease	☐	☐	☐	_____
Menstrual cramps	☐	☐	☐	_____
Mitral valve prolapse	☐	☐	☐	_____
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	☐	☐	☐	_____

Patient Signature _____ Date _____

Medical condition	Never	Current	Past	If past, enter date
Current pregnancy	☐	☐	☐	_____
Depression	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Difficulty concentrating	☐	☐	☐	_____
Difficulty sleeping	☐	☐	☐	_____
Dizziness/Vertigo	☐	☐	☐	_____
Emphysema	☐	☐	☐	_____
Epilepsy	☐	☐	☐	_____
Excessive thirst	☐	☐	☐	_____
Fibromyalgia	☐	☐	☐	_____
Fluid retention	☐	☐	☐	_____
Frequent cough	☐	☐	☐	_____
Frequent illnesses	☐	☐	☐	_____
Frequent stressful situations	☐	☐	☐	_____
Gastrointestinal Reflux Disease (GERD)	☐	☐	☐	_____
General anesthesia	☐	☐	☐	_____
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	☐	☐	☐	_____
Injury to teeth	☐	☐	☐	_____

Medical condition	Never	Current	Past	If past, enter date
Neuralgia	☐	☐	☐	_____
Numbness of fingers	☐	☐	☐	_____
Osteoarthritis	☐	☐	☐	_____
Osteoporosis	☐	☐	☐	_____
Ovarian cysts	☐	☐	☐	_____
Parkinson's disease	☐	☐	☐	_____
Poor circulation	☐	☐	☐	_____
Prior orthodontic treatment	☐	☐	☐	_____
Psychiatric care	☐	☐	☐	_____
Radiation treatment	☐	☐	☐	_____
Restless leg syndrome	☐	☐	☐	_____
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 frequent colds	☐	☐	☐	_____
Tendency for ear infections	☐	☐	☐	_____
Tendency for sore throats	☐	☐	☐	_____
Thyroid disorder	☐	☐	☐	_____
Tinnitis/Ringing in the ears	☐	☐	☐	_____
Tired muscles	☐	☐	☐	_____
Tonsils Removed	☐	☐	☐	_____
Tuberculosis	☐	☐	☐	_____
Tumors	☐	☐	☐	_____
Urinary disorders	☐	☐	☐	_____
Wisdom teeth extracted	☐	☐	☐	_____
Vertigo	☐	☐	☐	_____

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	☐	☐	☐	_____

Patient Signature _____ Date _____

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 _____	_____	_____
_____	_____	_____

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

__Yes __No Cancer	__Yes __No Obesity
__Yes __No Heart disease	__Yes __No Thyroid disorder
__Yes __No Diabetes	__Yes __No Father snores
__Yes __No High blood pressure	__Yes __No Mother snores
__Yes __No Stroke	__Yes __No Father has sleep apnea
__Yes __No Sleep disorder	__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 _____ Number of children:

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 _____