Medical History Questionnaire

OFFICE USE
Patient ID: ____

NAME: _____

FORM DATE: ____/____/_____

DATE OF BIRTH: ___/___/_____

Allergens

- ☐ No known allergens
- ☐ Antibiotics
- ☐ Aspirin
- ☐ Barbiturates
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local anesthetics
- ☐ Metals
- ☐ Penicillin
- ☐ Plastic
- ☐ Sedatives
- ☐ Sleeping pills
- ☐ Sulfa drugs

Current Medications

Medicine	Dosage/Frequency	Reason

Other

Medical History

Significant	Medical Condition	Current: Never	Current: Past	Date / Note	Significant	Medical Condition	Current: Never	Current: Past	Date / Note
☐	Acid reflux/ulcers	☐	☐		☐	Bleeding easily	☐	☐	
☐	Adenoids/Tonsils removed	☐	☐		☐	Blood pressure - High	☐	☐	
☐	A.I.D.S./H.I.V. positive	☐	☐		☐	Blood pressure - Low	☐	☐	
☐	Anemia	☐	☐		☐	Bruising easily	☐	☐	
☐	Arteriosclerosis	☐	☐		☐	Cancer	☐	☐	
☐	Arthritis	☐	☐		☐	Carpal tunnel syndrome	☐	☐	
☐	Asthma	☐	☐		☐	Chemotherapy	☐	☐	
☐	Autoimmune disorder	☐	☐		☐	Chronic cough	☐	☐	

Patient Signature: _____ Date: _____

Medical History

Significant	Medical Condition	Current	Never	Past	Date / Note	Significant	Medical Condition	Current	Never	Past	Date / Note
☐	Chronic fatigue	☐	☐	☐		☐	Mood disorder	☐	☐	☐	
☐	Chronic pain	☐	☐	☐		☐	Heart valve replacement	☐	☐	☐	
☐	COPD	☐	☐	☐		☐	Hemophilia	☐	☐	☐	
☐	Current pregnancy	☐	☐	☐		☐	Hepatitis	☐	☐	☐	
☐	Depression	☐	☐	☐		☐	Hypoglycemia	☐	☐	☐	
☐	Diabetes	☐	☐	☐		☐	Immune system disorder	☐	☐	☐	
☐	Diet (special/restricted)	☐	☐	☐		☐	Injury to face/mouth/neck	☐	☐	☐	
☐	Difficulty concentrating	☐	☐	☐		☐	Insomnia	☐	☐	☐	
☐	Difficulty sleeping	☐	☐	☐		☐	Intestinal disorders	☐	☐	☐	
☐	Dizziness	☐	☐	☐		☐	Kidney problems	☐	☐	☐	
☐	Emphysema	☐	☐	☐		☐	Liver disease	☐	☐	☐	
☐	Epilepsy	☐	☐	☐		☐	Low energy	☐	☐	☐	
☐	Excessive thirst	☐	☐	☐		☐	Meniere's disease	☐	☐	☐	
☐	Fibromyalgia	☐	☐	☐		☐	Multiple sclerosis	☐	☐	☐	
☐	Frequent cough	☐	☐	☐		☐	Muscle aches/tiredness	☐	☐	☐	
☐	Frequent illnesses	☐	☐	☐		☐	Muscle shaking (tremors)	☐	☐	☐	
☐	Glaucoma	☐	☐	☐		☐	Muscle spasms or cramps	☐	☐	☐	
☐	Gout	☐	☐	☐		☐	Muscular dystrophy	☐	☐	☐	
☐	Hayfever	☐	☐	☐		☐	Nasal allergies	☐	☐	☐	
☐	Ischemic heart disease (reduced blood supply)	☐	☐	☐		☐	Need extra pillows to help breathing at night	☐	☐	☐	
☐	Headaches	☐	☐	☐		☐	Nervousness	☐	☐	☐	
☐	Heart attack	☐	☐	☐		☐	Neuralgia	☐	☐	☐	
☐	Heart disorder	☐	☐	☐		☐	Night sweats	☐	☐	☐	
☐	Heart murmur	☐	☐	☐		☐	Osteoarthritis	☐	☐	☐	
☐	Heart pacemaker	☐	☐	☐		☐	Osteoporosis	☐	☐	☐	

Patient Signature: _____ Date: _____

Medical History

Significant	Medical Condition	Current: Never	Current: Past	Date / Note	Significant	Medical Condition	Current: Never	Current: Past	Date / Note
☐	Parkinson's disease	☐	☐		☐	Swelling in ankles or feet	☐	☐	
☐	Radiation treatment	☐	☐		☐	Tendency for ear infections	☐	☐	
☐	Psychiatric care	☐	☐		☐	Tendency for frequent colds	☐	☐	
☐	Rheumatic fever	☐	☐		☐	Tendency for sore throats	☐	☐	
☐	Shortness of breath	☐	☐		☐	Thyroid disorder	☐	☐	
☐	Sleep apnea	☐	☐		☐	Tuberculosis	☐	☐	
☐	Sickle cell disease	☐	☐		☐	Tumors	☐	☐	
☐	Sinus problems	☐	☐		☐	Urinary disorders	☐	☐	
☐	Speech difficulties	☐	☐		☐	Weight gain	☐	☐	
☐	Stroke	☐	☐						

Other

	Medical Condition	Current	Past	Date / Note		Medical Condition	Current	Past	Date / Note
☐		☐	☐		☐		☐	☐	

Dental History

Current dental problems (if any)

Current Dentist's name, address and phone

Date of last dental visit

Last full mouth xrays or panorex

Last dental cleaning

How often do you have dental examinations?

How often do you brush your teeth?

How often do you floss?

☐ Current or past use of topical fluoride

☐ Sensitive teeth

☐ Gums bleed or hurt

☐ Loose teeth

☐ Noticed a change in bite

☐ Mouth odors or bad tastes

☐ Food becomes caught between your teeth

☐ Clench or grind your teeth

☐ Bite your lips or cheeks regularly

☐ Hold foreign objects with your teeth (pencils, pens, nails, fingernails)

☐ Have tired jaws, especially in the morning

Patient Signature:

Date:

Dental History

- ☐ Mouth breathe while awake or asleep
- ☐ Had past Orthodontic treatment
- ☐ Have seen a Periodontist
- ☐ Past oral surgery
- ☐ Your bite has been adjusted in the past
- ☐ Have had a bite plate or mouth guard made
- ☐ Have been told you have a TMJ problem
- ☐ Jaw clicks or pops
- ☐ Difficulty opening or closing mouth

Other

- ☐ Difficulty in chewing on either side of your mouth
- ☐ Difficulty in opening or closing your mouth
- ☐ Smoke/chew tobacco or use other tobacco products

If you are not happy with the appearance of your teeth, what would you like to change?

- ☐ Want to keep your teeth all your life

If you feel nervous about having dental treatment, what is your biggest concern?

If you have ever had an upsetting dental experience, describe it briefly

Is there anything else about having dental treatment that you would like us to know?

Confidential Medical History

Significant	Medical Condition	Current: Never	Current: Past	Date / Note
☐	Recreational drugs	☐	☐	
☐	HIV/AIDS	☐	☐	

Significant	Medical Condition	Current: Never	Current: Past	Date / Note

Surgical Operations

- ☐ Appendectomy
- ☐ Back
- ☐ Ear
- ☐ Gallbladder
- ☐ Heart
- ☐ Hernia repair
- ☐ Lung
- ☐ Nasal
- ☐ Thyroid
- ☐ Tonsillectomy
- ☐ Uvulectomy
- ☐ Periodontal
- ☐ Kidney
- ☐ Bariatric

Other

Family History

Has any member of your family (parent, sibling, or grandparent) had:

- ☐ Cancer
- ☐ Heart disease
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Stroke
- ☐ Sleep disorder
- ☐ Obesity
- ☐ Thyroid trouble
- ☐ Father snores
- ☐ Mother snores
- ☐ Father has sleep apnea
- ☐ Mother has sleep apnea

Patient Signature:

Date:

Social History

Patient's Occupation _____ Employer _____

Tobacco Use: Cigarettes ☐ Never smoked ☐ Current smoker ☐ Quit

# of packs per day _____ When did you quit? _____

# of years _____

Other tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

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

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

Additional:

☐ Regular exercise

Patient Signature

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

Patient Signature: _____ Date: _____

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

Patient Signature: _____ Date: _____