Medical History Questionnaire

NAME: _____ _____ _____
First Middle Initial Last

FORM DATE: ____ /____ /_____

DATE OF BIRTH: ____ /____ /_____

This questionnaire was designed to provide important facts regarding your medical history or condition. The information you provide will assist in altering treatment for safety as needed, reaching a diagnosis and determining the source of any problem you may have. Please take your time and answer each question as completely and honestly as possible. Please Initial each page.

FAMILY OR PRIMARY CARE PHYSICIAN: _____Phone #: _____

ADDRESS: _____

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

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

LIST ANY MEDICATIONS CURRENTLY BEING TAKEN **(Write below or attach medication list)**:

Medication Name	Dosage/Frequency	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other Items: _____ _____ _____

FOR OFFICE USE ONLY:

_____
_____
_____
_____
_____
_____
_____
_____

Patient Initials: _____ Date _____

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

Medical Condition	Never	Past	Current	If Past, entry date
Acid reflux	☐	☐	☐	_____
Anemia	☐	☐	☐	_____
Arteriosclerosis	☐	☐	☐	_____
Arthritis	☐	☐	☐	_____
Asthma	☐	☐	☐	_____
Autoimmune disorder	☐	☐	☐	_____
Bleeding easily	☐	☐	☐	_____
Blood pressure – High	☐	☐	☐	_____
Blood pressure – Low	☐	☐	☐	_____
Bruising easily	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Chemotherapy	☐	☐	☐	_____
Chronic fatigue	☐	☐	☐	_____
Chronic pain	☐	☐	☐	_____
COPD	☐	☐	☐	_____
Current pregnancy	☐	☐	☐	_____
Depression	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Difficulty sleeping	☐	☐	☐	_____
Dizziness	☐	☐	☐	_____
Emphysema	☐	☐	☐	_____
Epilepsy	☐	☐	☐	_____
Fibromyalgia	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Gout	☐	☐	☐	_____
Heart attack	☐	☐	☐	_____
Heart disorder	☐	☐	☐	_____
Heart murmur	☐	☐	☐	_____
Heart pacemaker	☐	☐	☐	_____
Heart valve replacement	☐	☐	☐	_____
Hemophilia	☐	☐	☐	_____
Hepatitis	☐	☐	☐	_____
Hypertension	☐	☐	☐	_____
Hypoglycemia	☐	☐	☐	_____
Immune system disorder	☐	☐	☐	_____

Medical Condition	Never	Past	Current	If Past, entry date
Joint Replacement	☐	☐	☐	_____
Kidney problems	☐	☐	☐	_____
Liver disease	☐	☐	☐	_____
Meniere's disease	☐	☐	☐	_____
Mitral valve prolapse	☐	☐	☐	_____
Mood Disorder	☐	☐	☐	_____
Multiple sclerosis	☐	☐	☐	_____
Muscular dystrophy	☐	☐	☐	_____
Nasal allergies	☐	☐	☐	_____
Neuralgia	☐	☐	☐	_____
Osteoarthritis	☐	☐	☐	_____
Osteoporosis	☐	☐	☐	_____
Parkinson's disease	☐	☐	☐	_____
Psychiatric care	☐	☐	☐	_____
Radiation treatment	☐	☐	☐	_____
Rheumatic fever	☐	☐	☐	_____
Rheumatoid arthritis	☐	☐	☐	_____
Sinus problems	☐	☐	☐	_____
Sleep apnea	☐	☐	☐	_____
Chronic Snoring	☐	☐	☐	_____
Stroke	☐	☐	☐	_____
Taking a Bisphosphonate	☐	☐	☐	_____
Tendency for ear infections	☐	☐	☐	_____
Thyroid disorder	☐	☐	☐	_____
Tuberculosis	☐	☐	☐	_____
Tumors	☐	☐	☐	_____
Urinary disorders	☐	☐	☐	_____
Prior orthodontic treatment	☐	☐	☐	_____
Other:				
_____	☐	☐	☐	_____
_____	☐	☐	☐	_____
_____	☐	☐	☐	_____
_____	☐	☐	☐	_____
_____	☐	☐	☐	_____

ADDITIONAL MEDICAL HISTORY ITEMS (Confidential):

Medical Condition	Never	Past	Current	If Past, entry date
Recreational drugs	☐	☐	☐	_____

Medical Condition	Never	Past	Current	If Past, entry date
HIV/AIDS	☐	☐	☐	_____

LIST ANY SURGICAL OPERATIONS YOU HAVE HAD:

Appendectomy	☐ Yes ☐ No	Heart	☐ Yes ☐ No	Thyroid	☐ Yes ☐ No
Back	☐ Yes ☐ No	Hernia repair	☐ Yes ☐ No	Tonsillectomy	☐ Yes ☐ No
Ear	☐ Yes ☐ No	Lung	☐ Yes ☐ No	Uvulectomy	☐ Yes ☐ No
Gallbladder	☐ Yes ☐ No	Nasal	☐ Yes ☐ No	Periodontal	☐ Yes ☐ No

Other: _____ _____ _____

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

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	☐ Yes ☐ No

SOCIALial History:

Patient's Occupation: _____ Employer: _____

Tobacco Use:

☐ Never smoked ☐ Cigarettes ☐ Pipe ☐ Cigar ☐ Chew ☐ Snuff

☐ Quit Smoking. When did you quit:_____

If current smoker, the # of packs per day: _____

Alcohol Use:

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

How often do you consume alcohol within 2-3 hours of bedtime?

☐ Never ☐ Once a week ☐ Several days a week ☐ Daily

Caffeine Intake:

☐ None ☐ Coffee ☐ Tea ☐ Soda # cups per day: _____

How often do you consume caffeine within 2-3 hours of bedtime?

☐ Never ☐ Once a week ☐ Several days a week ☐ Daily

Additional:

How often do you take sedatives within 2-3 hours of bedtime?

☐ Neve r ☐ Once a week ☐ Several days a week ☐ Daily

Regular exercise ☐ Yes ☐ No

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 _____