

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	<input type="checkbox"/> Yes <input type="checkbox"/> No	Latex	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sleeping pills	<input type="checkbox"/> Yes <input type="checkbox"/> No
Antibiotics	<input type="checkbox"/> Yes <input type="checkbox"/> No	Local anesthetics	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sulfa drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Aspirin	<input type="checkbox"/> Yes <input type="checkbox"/> No	Metals	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other:	_____
Barbiturates	<input type="checkbox"/> Yes <input type="checkbox"/> No	Penicillin	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other:	_____
Codeine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Plastic	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other:	_____
Iodine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sedatives	<input type="checkbox"/> Yes <input type="checkbox"/> No		

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	Medical Condition	Never	Past	Current	If Past, entry date
Acid reflux	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Joint Replacement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arteriosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Meniere's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Autoimmune disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Mood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood pressure – High	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood pressure – Low	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Nasal allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bruising easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Neuralgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Psychiatric care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
COPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Radiation treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Current pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Chronic Snoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Taking a Bisphosphonate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tendency for ear infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Thyroid disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tumors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Urinary disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Prior orthodontic treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other:				
Heart valve replacement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Immune system disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

ADDITIONAL MEDICAL HISTORY ITEMS (Confidential):

Medical Condition	Never	Past	Current	If Past, entry date	Medical Condition	Never	Past	Current	If Past, entry date
Recreational drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

LIST ANY SURGICAL OPERATIONS YOU HAVE HAD:

Appendectomy Yes No
 Back Yes No
 Ear Yes No
 Gallbladder Yes No

Heart Yes No
 Hernia repair Yes No
 Lung Yes No
 Nasal Yes No

Thyroid Yes No
 Tonsillectomy Yes No
 Uvulectomy Yes No
 Periodontal Yes No

Other: _____

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

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 Yes No

SOCIAL 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?

Never 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 _____