

# Medical History Questionnaire

OFFICE USE Patient ID: _____
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NAME: \_\_\_\_\_  
First Middle Initial Last

TODAY'S DATE \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

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

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

Y <input type="checkbox"/>	N <input type="checkbox"/>	Antibiotics	Y <input type="checkbox"/>	N <input type="checkbox"/>	Latex	Y <input type="checkbox"/>	N <input type="checkbox"/>	Sedatives
Y <input type="checkbox"/>	N <input type="checkbox"/>	Aspirin	Y <input type="checkbox"/>	N <input type="checkbox"/>	Local anesthetics	Y <input type="checkbox"/>	N <input type="checkbox"/>	Sleeping pills
Y <input type="checkbox"/>	N <input type="checkbox"/>	Barbiturates	Y <input type="checkbox"/>	N <input type="checkbox"/>	Metals	Y <input type="checkbox"/>	N <input type="checkbox"/>	Sulfa drugs
Y <input type="checkbox"/>	N <input type="checkbox"/>	Codeine	Y <input type="checkbox"/>	N <input type="checkbox"/>	Penicillin			
Y <input type="checkbox"/>	N <input type="checkbox"/>	Iodine	Y <input type="checkbox"/>	N <input type="checkbox"/>	Plastic			

Other \_\_\_\_\_

## LIST ANY MEDICATIONS CURRENTLY BEING TAKEN:

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

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

Medical condition	Never	Current	Past	If past, enter date	Medical condition	Never	Current	Past	If past, enter date
Acid reflux	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Adenoids Removed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Intestinal disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Jaw joint surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arteriosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Low energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Autoimmune disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Meniere's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Menstrual cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood pressure - High	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood pressure - Low	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Muscle aches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bruising easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Muscle shaking (tremors)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Muscle spasms or cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Nasal allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Needing extra pillows to help breathing at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Nervous system irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cold hands and feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
COPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Neuralgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Numbness of fingers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

Medical condition	Never	Current	Past	If past, enter date
Difficulty sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Excessive thirst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fluid retention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent illnesses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent stressful situations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
General anesthesia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hearing impaired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart valve replacement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Immune system disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Injury to face	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Injury to mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Injury to neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Injury to teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

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

Other	Current	Past	If past, enter date
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

**ADDITIONAL MEDICAL HISTORY ITEMS:**

Recreational drugs	Never	Current	Past	If past, enter date
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

HIV/AIDS	Never	Current	Past	If past, enter date
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

**LIST ANY SURGICAL OPERATIONS YOU HAVE HAD:**

Y <input type="checkbox"/>	N <input type="checkbox"/>	Appendectomy
Y <input type="checkbox"/>	N <input type="checkbox"/>	Back
Y <input type="checkbox"/>	N <input type="checkbox"/>	Ear
Y <input type="checkbox"/>	N <input type="checkbox"/>	Gallbladder

Y <input type="checkbox"/>	N <input type="checkbox"/>	Heart
Y <input type="checkbox"/>	N <input type="checkbox"/>	Hernia repair
Y <input type="checkbox"/>	N <input type="checkbox"/>	Lung
Y <input type="checkbox"/>	N <input type="checkbox"/>	Nasal

Y <input type="checkbox"/>	N <input type="checkbox"/>	Thyroid
Y <input type="checkbox"/>	N <input type="checkbox"/>	Tonsillectomy
Y <input type="checkbox"/>	N <input type="checkbox"/>	Uvulectomy
Y <input type="checkbox"/>	N <input type="checkbox"/>	Periodontal

Other	_____	_____	_____
	_____	_____	_____

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

Y  N  Cancer  
Y  N  Heart disease  
Y  N  Diabetes  
Y  N  High blood pressure

Y  N  Stroke  
Y  N  Sleep disorder  
Y  N  Obesity  
Y  N  Thyroid trouble

Y  N  Father snores  
Y  N  Mother snores  
Y  N  Father has sleep apnea  
Y  N  Mother has sleep apnea

Other \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SOCIAL HISTORY:**

**Tobacco Use:**

Cigarettes  Never smoked

Current smoker

Quit

# packs per day \_\_\_\_\_

# of years \_\_\_\_\_

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:**

Y  N  Regular exercise

Y  N

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 \_\_\_\_\_