

# CONFIDENTIAL

## LIBERTY DENTAL ASSOCIATES PATIENT MEDICAL HISTORY/QUESTIONNAIRE

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Health Summary:  
(Office Use Only)

**PLEASE COMPLETE THE FOLOWING FORM (3 PAGES):**

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_ YES NO

1. Please list your Medical Doctor's name, address, and phone number: \_\_\_\_\_  
\_\_\_\_\_

2. Have you been to see this Medical Doctor or another one within the past 2 years?  
If yes, for what?: \_\_\_\_\_

3. Have you been a patient in the hospital with the past 2 years? \_\_\_\_\_ If yes, for what?: \_\_\_\_\_

4. Please check (✓)any condition below which you have had in the past, or now have:

<p><b>GENERAL</b></p> <p><input type="checkbox"/>-Tire Easily/Weakness <input type="checkbox"/>-Marked Weight Change <input type="checkbox"/>-Night Sweats <input type="checkbox"/>-Persistent Fever <input type="checkbox"/>-Poor General Health</p> <p><b>SKIN &amp; MOUTH TISSUES (GUMS)</b></p> <p><input type="checkbox"/>-Rash, Hives, Eruptions <input type="checkbox"/>-Change in Skin Color <input type="checkbox"/>-Change in Mole (Color, Shape, Size) <input type="checkbox"/>-Cold Sores, Fever Blisters <input type="checkbox"/>-Sores in Mouth <input type="checkbox"/>-Herpes <input type="checkbox"/>-Bleeding Gums</p> <p><b>EYES</b></p> <p><input type="checkbox"/>-Visual Changes <input type="checkbox"/>-Glaucoma</p> <p><b>NOSE</b></p> <p><input type="checkbox"/>-Frequent Nosebleeds <input type="checkbox"/>-Sinus Problems <input type="checkbox"/>-Seasonal Allergies</p> <p><b>EARS</b></p> <p><input type="checkbox"/>-Loss of Hearing <input type="checkbox"/>-Reduction in Hearing <input type="checkbox"/>-Wear Hearing Aids <input type="checkbox"/>-Ringing in Ears</p> <p><b>BONES AND MUSCLES</b></p> <p><input type="checkbox"/>-Osteoporosis <input type="checkbox"/>-Arthritis/Rheumatism <input type="checkbox"/>-Artificial Joints/Limbs/Hips <input type="checkbox"/>-Plates, Pins, or Screws Placed <input type="checkbox"/>-Cortisone Therapy/Treatment <input type="checkbox"/>-Enlarged "Gland" or Lymph Nodes</p>	<p><b>THROAT</b></p> <p><input type="checkbox"/>-Soreness <input type="checkbox"/>-Hoarseness <input type="checkbox"/>-Growths</p> <p><b>NERVOUS SYSTEM</b></p> <p><input type="checkbox"/>-Stroke <input type="checkbox"/>-Headaches <input type="checkbox"/>-Convulsions/Seizures <input type="checkbox"/>-Epilepsy <input type="checkbox"/>-Numbness/Tingling <input type="checkbox"/>-Dizziness <input type="checkbox"/>-Fainting <input type="checkbox"/>-Anorexia <input type="checkbox"/>-Bulimia <input type="checkbox"/>-Psychological Treatment <input type="checkbox"/>-Psychiatric Treatment <input type="checkbox"/>-General Nervousness</p> <p><b>RESPIRATORY</b></p> <p><input type="checkbox"/>-Tuberculosis <input type="checkbox"/>-Emphysema <input type="checkbox"/>-Lung Disease <input type="checkbox"/>-Hay Fever <input type="checkbox"/>-Asthma <input type="checkbox"/>-Persistent Cough <input type="checkbox"/>-Excessive Sputum (phlegm) <input type="checkbox"/>-Bloody Sputum (phlegm) <input type="checkbox"/>-Difficulty Breathing While Lying Down <input type="checkbox"/>-Bronchitis</p> <p><b>DIGESTIVE SYSTEM</b></p> <p><input type="checkbox"/>-Jaundice <input type="checkbox"/>-Liver Disease <input type="checkbox"/>-Alcohol Treatment <input type="checkbox"/>-Ulcers <input type="checkbox"/>-Change in Appetite <input type="checkbox"/>-Black, Bloody, or Pale Stools</p>	<p><b>ENDOCRINE</b></p> <p><input type="checkbox"/>-Diabetes <input type="checkbox"/>-Family History of Diabetes <input type="checkbox"/>-Thyroid Condition or Goiter</p> <p><b>HEART AND BLOOD VESSELS</b></p> <p><input type="checkbox"/>-Rheumatic Fever <input type="checkbox"/>-Heart Murmur <input type="checkbox"/>-Chest Pains/Discomfort <input type="checkbox"/>-Mitral Valve Prolapse <input type="checkbox"/>-Hypertension <input type="checkbox"/>-Hemophilia <input type="checkbox"/>-Other Blood Dyscrasia <input type="checkbox"/>-Hepatitis; Type: _____ <input type="checkbox"/>-Yellow Jaundice <input type="checkbox"/>-Blood Transfusions <input type="checkbox"/>-Congenital Heart Lesions <input type="checkbox"/>-Artificial Heart Valve <input type="checkbox"/>-Heart Pacemaker <input type="checkbox"/>-Angina Pectoris (Chest Pain) <input type="checkbox"/>-Heart Failure/Attack <input type="checkbox"/>-Heart Problems <input type="checkbox"/>-Heart Disease <input type="checkbox"/>-Heart Surgery <input type="checkbox"/>-Angiogram <input type="checkbox"/>-Angioplasty/Stent Placement <input type="checkbox"/>-High Blood Pressure <input type="checkbox"/>-Low Blood Pressure <input type="checkbox"/>-Shortness of Breath</p> <p><b>URINARY</b></p> <p><input type="checkbox"/>-Kidney Disease <input type="checkbox"/>-Increase in Frequency of Urination <input type="checkbox"/>-Burning on Urination <input type="checkbox"/>-Urethral Discharge <input type="checkbox"/>-Blood in Urine <input type="checkbox"/>-Venereal Disease <input type="checkbox"/>-Kidney Stones</p>	<p><b>BLOOD</b></p> <p><input type="checkbox"/>-Bruise Easily <input type="checkbox"/>-Anemia <input type="checkbox"/>-Blood Transfusion <input type="checkbox"/>-Bleeding Tendency <input type="checkbox"/>-Circulatory Problems</p> <p><b>OTHER</b></p> <p><input type="checkbox"/>-Latex Sensitivity/Allergy <input type="checkbox"/>-X-Ray or Radiation Therapy <input type="checkbox"/>-Chemotherapy <input type="checkbox"/>-Tumors or Growths <input type="checkbox"/>-Cancer <input type="checkbox"/>-Leukemia <input type="checkbox"/>-A.I.D.S. <input type="checkbox"/>-A.R.C. (AIDS Related Complex) <input type="checkbox"/>-H.I.V. + <input type="checkbox"/>-Sickle Cell Anemia <input type="checkbox"/>-Respiratory Disease (Not listed) <input type="checkbox"/>-Malnutrition <input type="checkbox"/>-Drug Addiction <input type="checkbox"/>-Alcohol Intolerance <input type="checkbox"/>-Alcohol Addiction <input type="checkbox"/>-Back Surgery <input type="checkbox"/>-Chronic Backache <input type="checkbox"/>-Occasional Backache <input type="checkbox"/>-Vertigo <input type="checkbox"/>-Parental/Guardian Abuse <input type="checkbox"/>-Spousal Abuse <input type="checkbox"/>-Dementia <input type="checkbox"/>-Alzheimer's <input type="checkbox"/>-Xerostomia (Dry Mouth) <input type="checkbox"/>-Excessive Saliva <input type="checkbox"/>-Other (Please Describe):</p>
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- |   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| 5. Have you had any operations or surgeries? If yes, please describe: _____<br>Any complications, please list: _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever experienced any excessive bleeding requiring special treatment? If so, please describe: _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are you currently taking any medicines, drugs, or pills of any kind (including non-prescription or herbal):<br>If yes, please list name and dosage: _____<br>_____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have any allergies or adverse reactions to drugs or medicine? If yes, please describe _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Are you allergic to any dental anesthetics (Novocaine, Lidocaine, Nitrous Oxide, etc.)? If yes, what: _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. When you walk up stairs, or take a walk, do you ever have to stop because of pain in the chest, shortness of breath, or because you tire easily?                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do your ankles swell during the day?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you sleep on more than two pillows?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you wake from sleep, short of breath?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you <u>Unintentionally</u> lost or gained more than 10 pounds in the past year?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Are you on a special diet? If yes, please describe: _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Has a medical professional ever advised you that you have a cancer or tumor? If yes, please describe: _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Does your occupation bring you into contact with blood, blood products, or needles? If yes, please describe: _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Describe your overall health in your words: _____<br>_____  |                          |                          |
| 19. Do you take any type of sleeping pills, sedatives/tranquilizers, or barbiturates? If yes, please list: _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. If you have high blood pressure, is it well controlled with medicines? If no, please explain: _____<br>_____  | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Are you taking any blood thinners (including aspirin)? If yes, please list: _____<br>_____  |                          |                          |
| 22. Is there any condition, disease, or problem, not listed yet, that you think we need to know about? If yes, please list: _____                                     | <input type="checkbox"/> | <input type="checkbox"/> |

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## FOR FEMALE PATIENTS ONLY



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YES NO

1. Are you pregnant? If yes, please list due date: \_\_\_\_\_    
Any complications, please list: \_\_\_\_\_
2. Are you practicing birth control?    
If you are using birth control pills, please list type and dosage: \_\_\_\_\_  
\_\_\_\_\_
3. Do you anticipate becoming pregnant soon?
4. Do you suffer with PMS (Pre-Menstrual Syndrome), or problems associated with your menstrual period?    
If yes, please explain: \_\_\_\_\_
5. Are you taking any type of hormone therapy (other than birth control)?    
If yes, please describe: \_\_\_\_\_

### All Patients Please Read This Next Section—Then Sign And Date

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED ALL QUESTIONS, AND ADDRESSED ALL STATEMENTS ON ALL THREE PAGES OF THIS MEDICAL HISTORY/QUESTIONNAIRE FORM, HONESTLY AND CORRECTLY. IF THERE IS ANY CHANGE IN MY HEALTH, MEDICINES, ETC. I WILL INFORM THIS DENTAL OFFICE AT MY NEXT APPOINTMENT OR BEFORE. THIS INFORMATION IS FOR MEDICAL USE ONLY (per HIPAA Regulations). I ALSO AGREE TO ALLOW THIS CONFIDENTIAL INFORMATION TO BE SHARED WITH PHYSICIANS, HEALTH PROFESSIONALS, REFERRING DENTISTS, CLINICAL AND DENTAL LABORATORIES, PHARMACIES, OR ANY OTHER HEALTHCARE PERSONNEL PROVIDING ME TREATMENT:

DATE: \_\_\_\_\_ SIGNATURE OF PATIENT: \_\_\_\_\_  
(or Parent/Guardian if under age 18)

### FOR OFFICE USE ONLY

REVIEWED WITH THE PATIENT ON \_\_\_ / \_\_\_ / \_\_\_ SIGNATURE: \_\_\_\_\_

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FOR **MALE** PATIENTS ONLY



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Please advise this office of any changes in your medical health.

**All Patients Please Read This Next Section—Then Sign And Date**

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED ALL QUESTIONS, AND ADDRESSED ALL STATEMENTS ON ALL THREE PAGES OF THIS MEDICAL HISTORY/QUESTIONNAIRE FORM, HONESTLY AND CORRECTLY. IF THERE IS ANY CHANGE IN MY HEALTH, MEDICINES, ETC. I WILL INFORM THIS DENTAL OFFICE AT MY NEXT APPOINTMENT OR BEFORE. THIS INFORMATION IS FOR MEDICAL USE ONLY (per HIPAA Regulations). I ALSO AGREE TO ALLOW THIS CONFIDENTIAL INFORMATION TO BE SHARED WITH PHYSICIANS, HEALTH PROFESSIONALS, REFERRING DENTISTS, CLINICAL AND DENTAL LABORATORIES, PHARMACIES, OR ANY OTHER HEALTHCARE PERSONNEL PROVIDING ME TREATMENT:

DATE: \_\_\_\_\_ SIGNATURE OF PATIENT: \_\_\_\_\_  
(or Parent/Guardian if under age 18)

**FOR OFFICE USE ONLY**

REVIEWED WITH THE PATIENT ON \_\_\_ / \_\_\_ / \_\_\_ SIGNATURE: \_\_\_\_\_