Medical History Questionnaire

NAME: _____

FORM DATE: ____/____/_____

DATE OF BIRTH: ___/___/_____

Allergens

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

_____ _____

Current Medications

Medicine	Dosage/Frequency	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical History

Signific		Current				Significant		Current			
	Medical Condition	**Never**		**Past**	**Date / Note**		**Medical Condition**	**Never**		**Past**	**Date / Note**
☐	Acid reflux	☐	☐	☐	_____	☐	Blood pressure - High	☐	☐	☐	_____
☐	Adenoids Removed	☐	☐	☐	_____	☐	Blood pressure - Low	☐	☐	☐	_____
☐	Anemia	☐	☐	☐	_____	☐	Bruising easily	☐	☐	☐	_____
☐	Arteriosclerosis	☐	☐	☐	_____	☐	Cancer	☐	☐	☐	_____
☐	Arthritis	☐	☐	☐	_____	☐	Chemotherapy	☐	☐	☐	_____
☐	Asthma	☐	☐	☐	_____	☐	Chronic cough	☐	☐	☐	_____
☐	Autoimmune disorder	☐	☐	☐	_____	☐	Chronic fatigue	☐	☐	☐	_____
☐	Bleeding easily	☐	☐	☐	_____	☐	Chronic pain	☐	☐	☐	_____

Medical History

Significant	Medical Condition	Current Never	Current Past	Date / Note	Significant	Medical Condition	Current Never	Current Past	Date / Note
☐	Current pregnancy	☐	☐	_____	☐	Heart disorder	☐	☐	_____
☐	Cold hands and feet	☐	☐	_____	☐	Heart murmur	☐	☐	_____
☐	COPD	☐	☐	_____	☐	Heart pacemaker	☐	☐	_____
☐	Depression	☐	☐	_____	☐	Heart palpitations	☐	☐	_____
☐	Diabetes	☐	☐	_____	☐	Mitral valve prolapse	☐	☐	_____
☐	Difficulty concentrating	☐	☐	_____	☐	Heart valve replacement	☐	☐	_____
☐	Difficulty sleeping	☐	☐	_____	☐	Mood disorder	☐	☐	_____
☐	Dizziness	☐	☐	_____	☐	Hemophilia	☐	☐	_____
☐	Excessive Daytime Sleepiness	☐	☐	_____	☐	Hepatitis	☐	☐	_____
☐	Emphysema	☐	☐	_____	☐	Hypertension	☐	☐	_____
☐	Epilepsy	☐	☐	_____	☐	Hypoglycemia	☐	☐	_____
☐	Excessive thirst	☐	☐	_____	☐	Immune system disorder	☐	☐	_____
☐	Fibromyalgia	☐	☐	_____	☐	Injury to face	☐	☐	_____
☐	Fluid retention	☐	☐	_____	☐	Injury to mouth	☐	☐	_____
☐	Frequent cough	☐	☐	_____	☐	Injury to neck	☐	☐	_____
☐	Frequent illnesses	☐	☐	_____	☐	Injury to teeth	☐	☐	_____
☐	Frequent stressful situations	☐	☐	_____	☐	Insomnia	☐	☐	_____
☐	General anesthesia	☐	☐	_____	☐	Intestinal disorders	☐	☐	_____
☐	Glaucoma	☐	☐	_____	☐	Jaw joint surgery	☐	☐	_____
☐	Gout	☐	☐	_____	☐	Kidney problems	☐	☐	_____
☐	Hay fever	☐	☐	_____	☐	Liver disease	☐	☐	_____
☐	Hearing impaired	☐	☐	_____	☐	Low energy	☐	☐	_____
☐	Insomnia	☐	☐	_____	☐	Meniere's disease	☐	☐	_____
☐	Heart attack	☐	☐	_____	☐	Menstrual cramps	☐	☐	_____
☐	Ischemic heart disease (reduced blood supply)	☐	☐	_____	☐	Mitral valve prolapse	☐	☐	_____

Medical History

Significant	Medical Condition	Current Never	Current Past	Date / Note	Significant	Medical Condition	Current Never	Current Past	Date / Note
☐	Multiple sclerosis	☐	☐	_____	☐	Scarlet fever	☐	☐	_____
☐	Muscle aches	☐	☐	_____	☐	Scoliosis	☐	☐	_____
☐	Muscle shaking (tremors)	☐	☐	_____	☐	Shortness of breath	☐	☐	_____
☐	Muscle spasms or cramps	☐	☐	_____	☐	Sinus problems	☐	☐	_____
☐	Muscular dystrophy	☐	☐	_____	☐	Skin disorder	☐	☐	_____
☐	Nasal allergies	☐	☐	_____	☐	Sleep apnea	☐	☐	_____
☐	Needing extra pillows to help breathing at night	☐	☐	_____	☐	Slow healing sores	☐	☐	_____
☐	Nervous system irritability	☐	☐	_____	☐	Speech difficulties	☐	☐	_____
☐	Nervousness	☐	☐	_____	☐	Stroke	☐	☐	_____
☐	Neuralgia	☐	☐	_____	☐	Swelling in ankles or feet	☐	☐	_____
☐	Numbness of fingers	☐	☐	_____	☐	Swollen, stiff or painful joints	☐	☐	_____
☐	Osteoarthritis	☐	☐	_____	☐	Tendency for ear infections	☐	☐	_____
☐	Osteoporosis	☐	☐	_____	☐	Tendency for frequent colds	☐	☐	_____
☐	Ovarian cysts	☐	☐	_____	☐	Tendency for sore throats	☐	☐	_____
☐	Parkinson's disease	☐	☐	_____	☐	Thyroid disorder	☐	☐	_____
☐	Poor circulation	☐	☐	_____	☐	Tired muscles	☐	☐	_____
☐	Prior orthodontic treatment	☐	☐	_____	☐	Tonsils Removed	☐	☐	_____
☐	Psychiatric care	☐	☐	_____	☐	Tuberculosis	☐	☐	_____
☐	Radiation treatment	☐	☐	_____	☐	Tumors	☐	☐	_____
☐	Rheumatic fever	☐	☐	_____	☐	Urinary disorders	☐	☐	_____
☐	Rheumatoid arthritis	☐	☐	_____	☐	Wisdom teeth (third molar) extraction	☐	☐	_____

Other

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

Confidential Medical History

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

Surgical Operations

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

Other

_____ _____ _____

Family History

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

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

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

Because of HIPAA Federal regulations protecting your privacy, we wish to inform you that we will release no information about you without your consent. By agreeing to this consent, you permit the release of any information to or from your dental practitioner as required including a full report of examination findings, diagnosis and treatment program to any referring or treating dentist or physician. You understand that you are financially responsible for all charges whether or not paid by insurance. Your dental practitioner may use your health care information and may disclose such information to your Insurance Company(ies) and their agents for the purpose of obtaining payment for service and determining insurance benefits or the benefits payable for related services.

Patient Signature: Date:

_____ _____

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

Patient Signature: Date:

_____ _____