

# Medical History Questionnaire

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

FORM 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 a diagnosis and determining the source of your problem. Please take your time and answer each question as 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"/>	No known allergens	Y <input type="checkbox"/>	N <input type="checkbox"/>	Iodine	Y <input type="checkbox"/>	N <input type="checkbox"/>	Plastic
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			

Other \_\_\_\_\_

## LIST ANY MEDICATIONS CURRENTLY BEING TAKEN:

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

Other Items: \_\_\_\_\_

## MEDICAL HISTORY: (Please indicate dates on items marked 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"/>	_____	Irregular heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Jaw joint surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Autoimmune disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arteriosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Low energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Meniere's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood pressure - High	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Menstrual cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood pressure - Low	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bruising easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Muscle aches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Muscle shaking (tremors)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Muscle spasms or cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Nasal allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic sinus problems	<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"/>	_____
COPD	<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"/>	_____
CPAP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____					

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

Date \_\_\_\_\_

Medical condition	Never	Current	Past	If past, enter date
Current pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dizziness/Vertigo	<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"/>	_____
Gastrointestinal Reflux Disease (GERD)	<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
Neuralgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Numbness of fingers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
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"/>	_____
Restless leg syndrome	<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 frequent colds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tendency for ear infections	<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"/>	_____
Tinnitus/Ringing in the ears	<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 extracted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vertigo	<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"/>	_____

	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:**

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

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

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

Date \_\_\_\_\_

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

Y <input type="checkbox"/>	N <input type="checkbox"/>	Appendectomy	Y <input type="checkbox"/>	N <input type="checkbox"/>	Heart	Y <input type="checkbox"/>	N <input type="checkbox"/>	Thyroid
Y <input type="checkbox"/>	N <input type="checkbox"/>	Back	Y <input type="checkbox"/>	N <input type="checkbox"/>	Hernia repair	Y <input type="checkbox"/>	N <input type="checkbox"/>	Tonsillectomy
Y <input type="checkbox"/>	N <input type="checkbox"/>	Ear	Y <input type="checkbox"/>	N <input type="checkbox"/>	Lung	Y <input type="checkbox"/>	N <input type="checkbox"/>	Uvulectomy
Y <input type="checkbox"/>	N <input type="checkbox"/>	Gallbladder	Y <input type="checkbox"/>	N <input type="checkbox"/>	Nasal	Y <input type="checkbox"/>	N <input type="checkbox"/>	Periodontal

Other \_\_\_\_\_

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

<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Obesity
<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid disorder
<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Father snores
<input type="checkbox"/> Yes <input type="checkbox"/> No	High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mother snores
<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	Father has sleep apnea
<input type="checkbox"/> Yes <input type="checkbox"/> No	Sleep disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mother has sleep apnea

**SOCIAL HISTORY:**

Patient's Occupation \_\_\_\_\_ Employer \_\_\_\_\_

**Tobacco Use:** Cigarettes  Never smoked  Current smoker

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

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

Quit

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:**  Yes  No Regular exercise \_\_\_\_\_ Number of children: \_\_\_\_\_

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 \_\_\_\_\_