

Medical History Questionnaire

OFFICE USE
Patient ID: _____

NAME: _____

FORM DATE: ____/____/____

DATE OF BIRTH: ____/____/____

Allergens

- | | | |
|---|--|---|
| <input type="checkbox"/> No known allergens | <input type="checkbox"/> Iodine | <input type="checkbox"/> Plastic |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Latex | <input type="checkbox"/> Sedatives |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Local anesthetics | <input type="checkbox"/> Sleeping pills |
| <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Metals | <input type="checkbox"/> Sulfa drugs |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Penicillin | |

Current Medications

Medicine	Dosage/Frequency	Reason

Other _____

Medical History

Significant Medical Condition	Current		Date / Note	Significant Medical Condition	Current		Date / Note
	Never	Past			Never	Past	
<input type="checkbox"/> Acid reflux/ulcers	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Bleeding easily	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Adenoids/Tonsils removed	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Blood pressure - High	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> A.I.D.S./H.I.V. positive	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Blood pressure - Low	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Bruising easily	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Carpal tunnel syndrome	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Autoimmune disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	_____

Patient Signature: _____

Date: _____

Medical History

Significant	Medical Condition	Current	Never	Past	Date / Note	Significant	Medical Condition	Current	Never	Past	Date / Note
<input type="checkbox"/>	Chronic fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>	<input type="checkbox"/>	Mood disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>
<input type="checkbox"/>	Chronic pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>	<input type="checkbox"/>	Heart valve replacement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>
<input type="checkbox"/>	COPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>
<input type="checkbox"/>	Current pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>
<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>	<input type="checkbox"/>	Immune system disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>
<input type="checkbox"/>	Diet (special/restricted)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>	<input type="checkbox"/>	Injury to face/mouth/neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>
<input type="checkbox"/>	Difficulty concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>
<input type="checkbox"/>	Difficulty sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>	<input type="checkbox"/>	Intestinal disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>
<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>	<input type="checkbox"/>	Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>
<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>
<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>	<input type="checkbox"/>	Low energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>
<input type="checkbox"/>	Excessive thirst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>	<input type="checkbox"/>	Meniere's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>
<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>	<input type="checkbox"/>	Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>
<input type="checkbox"/>	Frequent cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>	<input type="checkbox"/>	Muscle aches/tiredness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>
<input type="checkbox"/>	Frequent illnesses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>	<input type="checkbox"/>	Muscle shaking (tremors)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>
<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>	<input type="checkbox"/>	Muscle spasms or cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>
<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>	<input type="checkbox"/>	Muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>
<input type="checkbox"/>	Hayfever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>	<input type="checkbox"/>	Nasal allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>
<input type="checkbox"/>	Ischemic heart disease (reduced blood supply)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>	<input type="checkbox"/>	Need extra pillows to help breathing at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>
<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>
<input type="checkbox"/>	Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>	<input type="checkbox"/>	Neuralgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>
<input type="checkbox"/>	Heart disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>	<input type="checkbox"/>	Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>
<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>
<input type="checkbox"/>	Heart pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>

Patient Signature:

Date:

Medical History

Significant Medical Condition	Current		Date / Note		Significant Medical Condition	Current		Date / Note
	Never	Past				Never	Past	
<input type="checkbox"/> Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	Swelling in ankles or feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
<input type="checkbox"/> Radiation treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	Tendency for ear infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
<input type="checkbox"/> Psychiatric care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	Tendency for frequent colds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	Tendency for sore throats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	Thyroid disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
<input type="checkbox"/> Sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
<input type="checkbox"/> Sickle cell disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	Tumors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
<input type="checkbox"/> Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	Urinary disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
<input type="checkbox"/> Speech difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	Weight gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>					
Other								
Medical Condition	Current	Past	Date / Note		Medical Condition	Current	Past	Date / Note
<input type="checkbox"/> <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

Dental History

Current dental problems (if any)

Current Dentist's name, address and phone

Date of last dental visit

Last full mouth xrays or panorex

Last dental cleaning

How often do you have dental examinations?

How often do you brush your teeth?

How often do you floss?

Current or past use of topical fluoride

Sensitive teeth

Gums bleed or hurt

Loose teeth

Noticed a change in bite

Mouth odors or bad tastes

Food becomes caught between your teeth

Clench or grind your teeth

Bite your lips or cheeks regularly

Hold foreign objects with your teeth (pencils, pens, nails, fingernails)

Have tired jaws, especially in the morning

Patient Signature:

Date:

Dental History

Mouth breathe while awake or asleep

Had past Orthodontic treatment

Have seen a Periodontist

Past oral surgery

Your bite has been adjusted in the past

Have had a bite plate or mouth guard made

Have been told you have a TMJ problem

Jaw clicks or pops

Difficulty opening or closing mouth

Other

Difficulty in chewing on either side of your mouth

Difficulty in opening or closing your mouth

Smoke/chew tobacco or use other tobacco products

If you are not happy with the appearance of your teeth, what would you like to change?

Want to keep your teeth all your life

If you feel nervous about having dental treatment, what is your biggest concern?

If you have ever had an upsetting dental experience, describe it briefly

Is there anything else about having dental treatment that you would like us to know?

Confidential Medical History

Significant Medical Condition	Current		Date / Note	Significant Medical Condition	Current		Date / Note
	Never	Past			Never	Past	
<input type="checkbox"/> Recreational drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>
<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input style="width: 50px;" type="text"/>

Surgical Operations

Appendectomy

Back

Ear

Gallbladder

Heart

Other

Hernia repair

Lung

Nasal

Thyroid

Tonsillectomy

Uvulectomy

Periodontal

Kidney

Bariatric

Family History

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

Cancer

Heart disease

Diabetes

High blood pressure

Stroke

Sleep disorder

Obesity

Thyroid trouble

Father snores

Mother snores

Father has sleep apnea

Mother has sleep apnea

Patient Signature:

Date:

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

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: