

Medical History Questionnaire

OFFICE USE
Patient ID: _____

NAME: _____

FORM DATE: ____/____/____

DATE OF BIRTH: ____/____/____

Allergens

- | | | |
|---|--|---|
| <input type="checkbox"/> No known allergies | <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 | <input type="checkbox"/> Other |

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 | <input type="checkbox"/> | <input type="checkbox"/> | _____ | <input type="checkbox"/> Blood pressure - High | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> Alzheimers | <input type="checkbox"/> | <input type="checkbox"/> | _____ | <input type="checkbox"/> Blood pressure - Low | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> | <input type="checkbox"/> | _____ | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> | <input type="checkbox"/> | _____ | <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> | <input type="checkbox"/> | _____ | <input type="checkbox"/> Bruising easily | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | _____ | <input type="checkbox"/> Cancer | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> | <input type="checkbox"/> | _____ | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> | <input type="checkbox"/> | _____ | <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> Autoimmune disorder | <input type="checkbox"/> | <input type="checkbox"/> | _____ | <input type="checkbox"/> Chronic pain | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> Bleeding easily | <input type="checkbox"/> | <input type="checkbox"/> | _____ | <input type="checkbox"/> Convulsions | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> | <input type="checkbox"/> | _____ | <input type="checkbox"/> COPD | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

Medical History

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|--|--------------------------|--------------------------|----------------------|--------------------------|----------------------------------|--------------------------|--------------------------|----------------------|
| | Never | Past | | | | Never | Past | |
| <input type="checkbox"/> Current pregnancy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> | <input type="checkbox"/> | Hypertension | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| <input type="checkbox"/> Depression | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> | <input type="checkbox"/> | Hypoglycemia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> | <input type="checkbox"/> | Immune system disorder | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> | <input type="checkbox"/> | Insomnia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> | <input type="checkbox"/> | Kidney problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| <input type="checkbox"/> Drug addiction | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> | <input type="checkbox"/> | Liver disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| <input type="checkbox"/> Dry Mouth | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> | <input type="checkbox"/> | Lung disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> | <input type="checkbox"/> | Meniere's disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> | <input type="checkbox"/> | Mitral valve prolapse | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> | <input type="checkbox"/> | Multiple sclerosis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> | <input type="checkbox"/> | Muscular dystrophy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| <input type="checkbox"/> Gout | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> | <input type="checkbox"/> | Nasal allergies | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> | <input type="checkbox"/> | Nervousness/Anxiety | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| <input type="checkbox"/> Heart angina | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> | <input type="checkbox"/> | Neuralgia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> | <input type="checkbox"/> | Pneumonia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| <input type="checkbox"/> Heart chest pains | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> | <input type="checkbox"/> | Osteoarthritis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| <input type="checkbox"/> Heart disorder | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> | <input type="checkbox"/> | Osteoporosis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| <input type="checkbox"/> Heart/erratic heartbeat | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> | <input type="checkbox"/> | Parkinson's disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| <input type="checkbox"/> Heart failure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> | <input type="checkbox"/> | Phen-Fen or Redux usage | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| <input type="checkbox"/> Heart mitral valve prolapse | <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"/> Heart murmur | <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"/> Heart pacemaker | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> | <input type="checkbox"/> | Recent weight loss | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| <input type="checkbox"/> Heart valve replacement | <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"/> Hemophilia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> | <input type="checkbox"/> | Rheumatoid arthritis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| <input type="checkbox"/> Hepatitis A, B, or C | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> | <input type="checkbox"/> | Scarlet fever | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| <input type="checkbox"/> Herpes | <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"/> HIV/AIDS | <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"/> Hives/Rash | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> | <input type="checkbox"/> | Sleep apnea | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |

Medical History

| Significant Medical Condition | Current | | Date / Note | Significant Medical Condition | Current | | Date / Note |
|--|--------------------------|--------------------------|----------------------|---|--------------------------|--------------------------|----------------------|
| | Never | Past | | | Never | Past | |
| <input type="checkbox"/> Stroke | <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"/> Stomach/intestinal disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> | <input type="checkbox"/> Venereal disease | <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"/> Women: Pregnant | <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"/> Trying to get pregnant | <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"/> Use of oral contraceptives | <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"/> Nursing | <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="text"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |

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 type="text"/> | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |

Surgical Operations

| | | |
|---------------------------------------|--|--|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Hernia repair | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Back | <input type="checkbox"/> Lung | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Ear | <input type="checkbox"/> Nasal | <input type="checkbox"/> Uvulectomy |
| <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Periodontal | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Heart | | |
| Other | | |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |

Social History

Patient's Occupation: Employer:

Tobacco Use: Cigarettes Never smoked Current smoker Quit

of packs per day:

of years:

When did you quit?

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: