Medical History Questionnaire

OFFICE USE
Patient ID:

NAME: _____ _ _____

FORM DATE: ___/___/_____

DATE OF BIRTH: ___/___/_____

Allergens

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

Current Medications

Medicine	Dosage/Frequency	Reason

Other

Medical History

Significant	Medical Condition	Current: Never	Current: Past	Date / Note	Significant	Medical Condition	Current: Never	Current: Past	Date / Note
☐	Acid reflux	☐	☐		☐	Cancer	☐	☐	
☐	Anemia	☐	☐		☐	Chemotherapy	☐	☐	
☐	Arteriosclerosis	☐	☐		☐	Chronic fatigue	☐	☐	
☐	Arthritis	☐	☐		☐	Chronic pain	☐	☐	
☐	Asthma	☐	☐		☐	COPD	☐	☐	
☐	Autoimmune disorder	☐	☐		☐	Current pregnancy	☐	☐	
☐	Bleeding easily	☐	☐		☐	Depression	☐	☐	
☐	Blood pressure - High	☐	☐		☐	Diabetes	☐	☐	
☐	Blood pressure - Low	☐	☐		☐	Difficulty sleeping	☐	☐	
☐	Bruising easily	☐	☐		☐	Dizziness	☐	☐	

Patient Signature: _____ Date: _____

Medical History

Significant	Medical Condition	Current: Never	Current: Past	Date / Note	Significant	Medical Condition	Current: Never	Current: Past	Date / Note
☐	Emphysema	☐	☐		☐	Muscular dystrophy	☐	☐	
☐	Epilepsy	☐	☐		☐	Nasal allergies	☐	☐	
☐	Fibromyalgia	☐	☐		☐	Neuralgia	☐	☐	
☐	Glaucoma	☐	☐		☐	Osteoarthritis	☐	☐	
☐	Gout	☐	☐		☐	Osteoporosis	☐	☐	
☐	Heart attack	☐	☐		☐	Parkinson's disease	☐	☐	
☐	Heart disorder	☐	☐		☐	Psychiatric care	☐	☐	
☐	Heart murmur	☐	☐		☐	Radiation treatment	☐	☐	
☐	Heart pacemaker	☐	☐		☐	Rheumatic fever	☐	☐	
☐	Heart valve replacement	☐	☐		☐	Rheumatoid arthritis	☐	☐	
☐	Hemophilia	☐	☐		☐	Sinus problems	☐	☐	
☐	Hepatitis	☐	☐		☐	Sleep apnea	☐	☐	
☐	Hypertension	☐	☐		☐	Stroke	☐	☐	
☐	Hypoglycemia	☐	☐		☐	Tendency for ear infections	☐	☐	
☐	Immune system disorder	☐	☐		☐	Thyroid disorder	☐	☐	
☐	Kidney problems	☐	☐		☐	Tuberculosis	☐	☐	
☐	Liver disease	☐	☐		☐	Tumors	☐	☐	
☐	Meniere's disease	☐	☐		☐	Urinary disorders	☐	☐	
☐	Mitral valve prolapse	☐	☐		☐	Prior orthodontic treatment	☐	☐	
☐	Multiple sclerosis	☐	☐						

Other

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

Confidential Medical History

Other

Medical Condition	Current	Past	Date / Note	Medical Condition	Current	Past	Date / Note
☐ Recreational drugs	☐	☐		☐ HIV/AIDS	☐	☐	

Surgical Operations

☐ Appendectomy ☐ Back ☐ Ear

Patient Signature: Date:

Surgical Operations

☐ Gallbladder	☐ Lung	☐ Tonsillectomy
☐ Heart	☐ Nasal	☐ Uvulectomy
☐ Hernia repair	☐ Thyroid	☐ 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 ☐ Snuff ☐ Cigar ☐ 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: