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	☐	☐		☐	Blood pressure - Low	☐	☐	
☐	Anemia	☐	☐		☐	Bruising easily	☐	☐	
☐	Arteriosclerosis	☐	☐		☐	Cancer	☐	☐	
☐	Arthritis	☐	☐		☐	Chemotherapy	☐	☐	
☐	Asthma	☐	☐		☐	Chronic fatigue	☐	☐	
☐	Autoimmune disorder	☐	☐		☐	Chronic pain	☐	☐	
☐	Bleeding easily	☐	☐		☐	COPD	☐	☐	
☐	Blood pressure - High	☐	☐		☐	Current pregnancy	☐	☐	

Patient Signature: _____ Date: _____

Medical History

Significant	Medical Condition	Current Never	Current Past	Date / Note	Significant	Medical Condition	Current Never	Current Past	Date / Note
☐	Depression	☐	☐		☐	Meniere's disease	☐	☐	
☐	Diabetes	☐	☐		☐	Mitral valve prolapse	☐	☐	
☐	Difficulty sleeping	☐	☐		☐	Multiple sclerosis	☐	☐	
☐	Dizziness	☐	☐		☐	Mood disorder	☐	☐	
☐	Emphysema	☐	☐		☐	Muscular dystrophy	☐	☐	
☐	Epilepsy	☐	☐		☐	Nasal allergies	☐	☐	
☐	Fibromyalgia	☐	☐		☐	Neuralgia	☐	☐	
☐	Excessive Daytime Sleepiness	☐	☐		☐	Osteoarthritis	☐	☐	
☐	Glaucoma	☐	☐		☐	Osteoporosis	☐	☐	
☐	Gout	☐	☐		☐	Parkinson's disease	☐	☐	
☐	Heart attack	☐	☐		☐	Psychiatric care	☐	☐	
☐	Heart disorder	☐	☐		☐	Radiation treatment	☐	☐	
☐	Heart murmur	☐	☐		☐	Rheumatic fever	☐	☐	
☐	Heart pacemaker	☐	☐		☐	Rheumatoid arthritis	☐	☐	
☐	Heart valve replacement	☐	☐		☐	Sinus problems	☐	☐	
☐	Hemophilia	☐	☐		☐	Sleep apnea	☐	☐	
☐	Hepatitis	☐	☐		☐	Stroke	☐	☐	
☐	Hypertension	☐	☐		☐	Tendency for ear infections	☐	☐	
☐	Hypoglycemia	☐	☐		☐	Thyroid disorder	☐	☐	
☐	Immune system disorder	☐	☐		☐	Tonsillectomy (have had)	☐	☐	
☐	Insomnia	☐	☐		☐	Tuberculosis	☐	☐	
☐	Insomnia	☐	☐		☐	Tumors	☐	☐	
☐	Irregular Heart Beat	☐	☐		☐	Urinary disorders	☐	☐	
☐	Ischemic heart disease (reduced blood supply)	☐	☐		☐	Prior orthodontic treatment	☐	☐	
☐	Kidney problems	☐	☐		☐	Wisdom Teeth Extraction	☐	☐	
☐	Liver disease	☐	☐						

Patient Signature: Date:

Medical History

Other

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

Confidential Medical History

Significant Medical Condition	Current Never	Current Past	Date / Note	Significant Medical Condition	Current 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: Date:

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: