

Medical History Questionnaire

OFFICE USE Patient ID: _____

NAME: _____
First Middle Initial Last

TODAY'S 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 N Antibiotics
Y N Aspirin
Y N Barbiturates
Y N Codeine
Y N Iodine

Y N Latex
Y N Local anesthetics
Y N Metals
Y N Penicillin
Y N Plastic

Y N Sedatives
Y N Sleeping pills
Y N Sulfa drugs

Other _____

LIST ANY MEDICATIONS CURRENTLY BEING TAKEN:

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

Patient Signature _____

Date _____

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
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Acid reflux	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Immune system disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Adenoids Removed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hearing impaired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Infectious mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arteriosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Injury to face/mouth/teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Jaw joint surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Autoimmune disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Backaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Lung disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood pressure - High	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood pressure - Low	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Nasal allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chest pains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
COPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Prior orthodontic treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Psychiatric care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Current pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Leg cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Low energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Swallowing problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Excessive thirst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fatigue easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Swollen, stiff or painful joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Muscle aches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Thyroid disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fluid retention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tonsils Removed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tumors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Neuralgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Polio	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart valve replacement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Swelling in ankles or feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Wear glasses or contacts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Other _____	Current	Past	If past, enter date	_____	_____	Current	Past	If past, enter date	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

LIST ANY SURGICAL OPERATIONS YOU HAVE HAD:

Y N Appendectomy
Y N Back
Y N Ear
Y N Gallbladder

Y N Heart
Y N Hernia repair
Y N Lung
Y N Nasal

Y N Thyroid
Y N Tonsillectomy
Y N Uvulectomy
Y N Periodontal

Other _____

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 _____