Medical History Questionnaire

OFFICE USE
Patient ID: ________

NAME: ________________________________
First *Middle Initial* *Last*

FORM DATE: __/__/____

DATE OF BIRTH: ________

This questionnaire was designed to provide important facts regardng 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 ☐ Latex	Y ☐ N ☐ Sedatives
Y ☐ N ☐ Aspirin	Y ☐ N ☐ Local anesthetics	Y ☐ N ☐ Sleeping pills
Y ☐ N ☐ Barbiturates	Y ☐ N ☐ Metals	Y ☐ N ☐ Sulfa drugs
Y ☐ N ☐ Codeine	Y ☐ N ☐ Penicillin	
Y ☐ N ☐ Iodine	Y ☐ N ☐ Plastic	

Other ____________ ____________ ____________

LIST ANY MEDICATIONS CURRENTLY BEING TAKEN:

Medication name	Dosage/ Frequency	Reason

Other Items: ____________ ____________

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
Acid reflux	☐	☐	☐		Injury to teeth	☐	☐	☐	
Adenoids Removed	☐	☐	☐		Insomnia	☐	☐	☐	
Anemia	☐	☐	☐		Intestinal disorders	☐	☐	☐	
Arteriosclerosis	☐	☐	☐		Jaw joint surgery	☐	☐	☐	
Arthritis	☐	☐	☐		Kidney problems	☐	☐	☐	
Asthma	☐	☐	☐		Liver disease	☐	☐	☐	
Autoimmune disorder	☐	☐	☐		Meniere's disease	☐	☐	☐	
Bleeding easily	☐	☐	☐		Menstrual cramps	☐	☐	☐	
Blood pressure - High	☐	☐	☐		Multiple sclerosis	☐	☐	☐	
Blood pressure - Low	☐	☐	☐		Muscle aches	☐	☐	☐	
Bruising easily	☐	☐	☐		Muscle shaking (tremors)	☐	☐	☐	
Cancer	☐	☐	☐		Muscle spasms or cramps	☐	☐	☐	
Chemotherapy	☐	☐	☐		Muscular dystrophy	☐	☐	☐	
Chronic cough	☐	☐	☐		Nasal allergies	☐	☐	☐	
Chronic fatigue	☐	☐	☐		Needing extra pillows to help breathing at night	☐	☐	☐	
Chronic pain	☐	☐	☐		Nervous system irritability	☐	☐	☐	
Cold hands and feet	☐	☐	☐		Nervousness	☐	☐	☐	
COPD	☐	☐	☐		Neuralgia	☐	☐	☐	
Current pregnancy	☐	☐	☐		Numbness of fingers	☐	☐	☐	
Depression	☐	☐	☐						

Patient Signature ________________________ Date ________________

Medical condition	Never	Current	Past	If past, enter date
Diabetes				
Difficulty concentrating				
Difficulty sleeping				
Dizziness				
Emphysema				
Epilepsy				
Excessive thirst				
Fibromyalgia				
Fluid retention				
Frequent cough				
Frequent illnesses				
Frequent stressful situations				
Glaucoma				
Gout				
Hay fever				
Hearing impaired				
Heart attack				
Heart disorder				
Heart murmur				
Heart pacemaker				
Heart palpitations				
Heart valve replacement				
Hemophilia				
Hepatitis				
Hypertension				
Hypoglycemia				
Immune system disorder				
Injury to face				
Injury to mouth				
Injury to neck				

Medical condition	Never	Current	Past	If past, enter date
Osteoarthritis				
Osteoporosis				
Ovarian cysts				
Parkinson's disease				
Poor circulation				
Prior orthodontic treatment				
Psychiatric care				
Radiation treatment				
Rheumatic fever				
Rheumatoid arthritis				
Scarlet fever				
Scoliosis				
Shortness of breath				
Sinus problems				
Skin disorder				
Sleep apnea				
Slow healing sores				
Speech difficulties				
Stroke				
Swelling in ankles or feet				
Swollen, stiff or painful joints				
Tendency for ear infections				
Tendency for frequent colds				
Tendency for sore throats				
Thyroid disorder				
Tired muscles				
Tonsils Removed				
Tuberculosis				
Tumors				
Urinary disorders				
Wisdom teeth (third molar) extraction				

Other	Current	Past	If past, enter date		Current	Past	If past, enter date

ADDITIONAL MEDICAL HISTORY ITEMS:

	Never	Current	Past	If past, enter date
Recreational drugs				
HIV/AIDS				

LIST ANY SURGICAL OPERATIONS YOU HAVE HAD:

Y	N		Y	N		Y	N	
		Appendectomy			Heart			Thyroid
		Back			Hernia repair			Tonsillectomy
		Ear			Lung			Uvulectomy
		Gallbladder			Nasal			Periodontal

Other ______________ ______________ ______________

______________ ______________ ______________

Patient Signature ______________________ Date ______________

FAMILY HISTORY

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

__Yes __No Cancer
__Yes __No Heart disease
__Yes __No Diabetes
__Yes __No High blood pressure
__Yes __No Stroke
__Yes __No Sleep disorder
__Yes __No Obesity
__Yes __No Thyroid disorder
__Yes __No Father snores
__Yes __No Mother snores
__Yes __No Father has sleep apnea
__Yes __No Mother has sleep apnea

SOCIAL HISTORY:

Patient's Occupation ________________ Employer ________________

Tobacco Use: Cigarettes ☐ Never smoked

☐ Current smoker
packs per day ___
of years ___

☐ Quit
When did you quit?
____

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 # cups per day: ___

Additional:

__Yes __No Regular exercise

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 ______________

Patient Signature ______________________ Date ______________

Patient Registration

CURRENT DATE: __/__/____

ID: ____________ Chart ID: ____________

First Name ____________ **Last Name** ____________ **Middle Initial** ________

Other Physician Name ______________________________

Responsible Party (If someone other than the patient)

Name ______________________________

Patient Information

Street Address ______________________________

City, State, Zip ______________________________

Home Phone ____________ Work Phone ____________ Ext. ______ Cell Phone ____________

☐ Male ☐ Female ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date ____________ Soc Sec # ____________

E-mail ____________ Spouse Name ____________

☐ Employed Student Status ☐ Full Time ☐ Part Time Height: Feet ___ Inches ___

INSURANCE INFORMATION

Primary Insurance Information

First Name of Insured ____________ Last Name ____________ Middle Initial ________

Policy/Group No. ____________ Relationship to insured ☐ Self ☐ Spouse

Insurance ID No. ____________ Insurance Plan or Program Name ____________ ☐ Child ☐ Other

Insured Birth Date ____________

Employer ____________

Insured Address if different than patient's

Street Address ____________

City, State, Zip ____________

Ins. Company ____________

Street Address ____________

____

City, State, Zip ____________

Secondary Insurance Information

First Name of Insured ____________ Last Name ____________ Middle Initial ________

Policy/Group No. ____________ Insurance Plan or Program Name ____________

Insured Birth Date ____________ Insurance ID No. ____________

Employer ____________

Insured Address if different than patient's

Street Address ____________

City, State, Zip ____________

Ins. Company ____________

Street Address ____________

____

City, State, Zip ____________