MEDICAL HISTORY QUESTIONNAIRE

Date:_____ Mobile Phone: (_____)_____

Name: _____ Home Phone: (_____)_____

Address: _____ Business Phone: (____)_____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Sex: M ___ F ___

Name of Spouse: _____ Emergency Contact: _____

Phone of Contact: (____)_____

Whom may we thank for referring you? _____

PART I: MEDICAL HISTORY:

1. Are you now, or have you been in the 12 past months, under the care of a physician? Y___ N___

For what reason? _____ Last medical appointment date_____

Name of physician: _____ Phone no: _____

2. Do you have any allergies or sensitivities that you know of? Y___ N___ If yes, state here: _____

3. List (or attach a list) any PRESCRIPTION OR OVER THE COUNTER MEDICATIONS that you are taking at the present time:

_____

4. Are you pregnant? Y___ N___ Are you taking oral contraceptives? Y___ N___

5. Chief complaint today _____

Have you been treated for this previously? Y___ N___

If yes, how long ago? _____

Type of previous treatment? Non-surgical ____ Surgical ____

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Name: _____

REVIEW OF SYSTEMS:

i. SKIN
Itching? Y___ N___ Rash? Y___ N___Ulcers? Y___ N___ Pigmentation? Y___ N___
Lack or loss of body hair? Y___ N___History of Shingles? Y___ N___

ii. EXTREMITIES
Varicose veins? Y___ N___ Swollen/painful joints? Y___ N___ Muscle weakness/pain? Y___ N___
Bone deformity/fractures? Y___ N___Prosthetic joints? Y___ N___

iii. EYES
Blurred vision? Y___ N___ Double vision? Y___ N___ Drooping eyelids? Y___ N___
Glaucoma Y___ N___

iv. EAR, NOSE, THROAT
Earache? Y___ N___ Hearing Loss? Y___ N___ Frequent nosebleed? Y___ N___
Sinusitis? Y___ N___ Frequent sore throat? Y___ N___ Hoarseness? Y___ N___
Jaw joint pain Y___ N___

v. RESPIRATORY
Cough? Y___ N___ Blood in sputum? Y___ N___ Emphysema? Y___ N___
Wheezing, asthma? Y___ N___ Tuberculosis, or exposure to TB?Y___ N___ Lung transplant? Y___ N___

vi. CARDIAC
Shortness of breath? Y___ N___ Pain, pressure in chest? Y___ N___ Swelling of ankles? Y___ N___
High/low blood pressure? Y___ N___ Rheumatic or scarlet fever? Y___ N___ Heart murmur? Y___ N___
History of heart attack? Y___ N___ Prosthetic valve? Y___ N___ Pacemaker? Y___ N___
Open heart surgery? Y___ N___ Heart transplant? Y___ N___

vii. GASTROINTESTINAL
Difficulty swallowing? Y___ N___ Abdominal pain, ulcers? Y___ N___ Heartburn? Y___ N___
Hepatitis, jaundice? Y___ N___ Liver disease? Y___ N___

viii. GENITOURINARY
Difficulty/pain on urination?Y___ N___ Blood in urine? Y___ N___ Excessive urination? Y___ N___
Kidney infections? Y___ N___ Urinary tract infections? Y___ N___ Sexually transmitted disease? Y___ N___

ix. ENDOCRINE
Thyroid issues? Y___ N___ Weight change? Y___ N___ Diabetes? Y___ N___
Excessive thirst? Y___ N___

xi. NEUROLOGIC
Frequent headaches? Y___ N___ Dizziness, fainting? Y___ N___ Epilepsy? Y___ N___
Neuritis/neuralgia? Y___ N___ Paresthesia/numbness? Y___ N___ Paralysis? Y___ N___

xii. PSYCHIATRIC
Nervousness? Y___ N___ Anxiety? Y___ N___ Depression? Y___ N___
Nervous breakdown? Y___ N___ Bi-polar disorder? Y___ N___

xiii. GROWTH OR TUMOR
History of Tumor? Y___ N___ If yes, type: _____
When diagnosed? Date: _____ Benign___ or Malignant___
Treatment: Radiation ___Chemotherapy___
In remission? Y___ N___ If yes, for how long? _____
Reoccurrence? Y___ N___ If yes, when: _____
Current tumor status: _____

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Name: _____

PART II: DENTAL HISTORY

1. Frequency of dental visits: Quarterly ___ Twice a year ___ Yearly ___ As needed ___

2. Problems with previous treatment? Describe: _____

3. Any adverse reactions to anesthetics, gloves, dental materials used? Y___ N___

If yes, describe: _____

4. Date of most recent complete X-rays: _____

PART III: FAMILY HISTORY

Have any members of your family ever been treated for the following conditions, or had any other medical problems not listed?

PLEASE CHECK ALL THAT APPLY:
Diabetes ___ High blood pressure ___ Heart problems ___ Cancer ___ Seizures ___ Mental disorder ___ HIV/AIDS ____
Other:___ _____

PART IV: SOCIAL HISTORY

Tobacco use? Y___N___ If yes, type: Cigarettes ___ Cigars ___ Chewing tobacco___ How often? _____
Alcohol? Y___N___ If yes, Occasionally ___ Socially ___Frequently ___ Daily___ # of drinks _____
Recreational drugs?Y___N___ If yes, Occasionally ___ Socially ___Frequently ___ Daily___

If the person completing the form is other than the patient, what is his/her relationship to the patient? _____

I certify that any and all questions that I had about the inquiries, above, have been answered to my satisfaction. I have answered these questions truthfully and completely. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I have made.

Signature of Patient: _____ Date signed: _____

Signature of Guardian (where applicable): _____ Date signed: _____

Additional comments on patient interview concerning medical history: _____

Significant finding from oral interview: _____

Patient management considerations: _____

Signature of Examining Doctor: _____