

# Medical History Questionnaire

OFFICE USE Patient ID: _____
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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 diagnosis and determining the source of your problem. Please take your time and answer each question a completely and honestly as possible. Please sign each page.

## LIST ANY MEDICATIONS/SUBSTANCES WHICH HAVE CAUSED AN ALLERGIC REACTION:

Y <input type="checkbox"/>	N <input type="checkbox"/>	Antibiotics	Y <input type="checkbox"/>	N <input type="checkbox"/>	Latex	Y <input type="checkbox"/>	N <input type="checkbox"/>	Sedatives
Y <input type="checkbox"/>	N <input type="checkbox"/>	Aspirin	Y <input type="checkbox"/>	N <input type="checkbox"/>	Local anesthetics	Y <input type="checkbox"/>	N <input type="checkbox"/>	Sleeping pills
Y <input type="checkbox"/>	N <input type="checkbox"/>	Barbiturates	Y <input type="checkbox"/>	N <input type="checkbox"/>	Metals	Y <input type="checkbox"/>	N <input type="checkbox"/>	Sulfa drugs
Y <input type="checkbox"/>	N <input type="checkbox"/>	Codeine	Y <input type="checkbox"/>	N <input type="checkbox"/>	Penicillin			
Y <input type="checkbox"/>	N <input type="checkbox"/>	Iodine	Y <input type="checkbox"/>	N <input type="checkbox"/>	Plastic			

Other \_\_\_\_\_

## LIST ANY MEDICATIONS CURRENTLY BEING TAKEN:

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

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

**MEDICAL HISTORY: (Please indicate dates on items marked current or past)**

Medical condition	Never	Current	Past	If past, enter date
Anemia				_____
Arteriosclerosis				_____
Asthma				_____
Autoimmune disorder				_____
Bleeding easily				_____
Blood pressure - High				_____
Blood pressure - Low				_____
Bruising easily				_____
Cancer				_____
Chest pains				_____
Chronic fatigue				_____
Current Pregnancy				_____
Congestive heart failure				_____
Diabetes				_____
Difficulty concentrating				_____
Dizziness				_____
Epilepsy				_____
Fibromyalgia				_____
Frequent sore throats				_____
Gastro Esophageal Reflux Disease (GERD)				_____
Hay fever				_____
Heart Disorder				_____
Heart beating or pounding irregularly during the night				_____
Heart pacemaker				_____
Heart valve replacement				_____
Hepatitis				_____
High Blood Pressure				_____
Immune system disorder				_____
Injury to face				_____

Medical condition	Never	Current	Past	If past, enter date
Injury to mouth				_____
Injury to neck				_____
Injury to teeth				_____
Insomnia				_____
Irregular heart beat				_____
Jaw joint surgery				_____
Low Blood Pressure				_____
Memory loss				_____
Migraines				_____
Morning dry mouth				_____
Muscle spasms or cramps				_____
Needing extra pillows to help breathing at night				_____
Nighttime sweating				_____
Osteoarthritis				_____
Osteoporosis				_____
Pacemaker				_____
Poor circulation				_____
Prior orthodontic treatment				_____
Recent excessive weight gain				_____
Rheumatic fever				_____
Shortness of breath				_____
Swelling in ankles or feet				_____
Swollen, stiff or painful joints				_____
Thyroid problems				_____
Tonsils Removed				_____
Wisdom teeth (third molar) extraction				_____
				_____
				_____
				_____

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

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

**ADDITIONAL MEDICAL HISTORY ITEMS:**

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

	Never	Current	Past	If past, enter date
				_____
				_____
				_____

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

**LIST ANY SURGICAL OPERATIONS YOU HAVE HAD:**

Y <input type="checkbox"/>	N <input type="checkbox"/>	Appendectomy	Y <input type="checkbox"/>	N <input type="checkbox"/>	Heart	Y <input type="checkbox"/>	N <input type="checkbox"/>	Thyroid
Y <input type="checkbox"/>	N <input type="checkbox"/>	Back	Y <input type="checkbox"/>	N <input type="checkbox"/>	Hernia repair	Y <input type="checkbox"/>	N <input type="checkbox"/>	Tonsillectomy
Y <input type="checkbox"/>	N <input type="checkbox"/>	Ear	Y <input type="checkbox"/>	N <input type="checkbox"/>	Lung	Y <input type="checkbox"/>	N <input type="checkbox"/>	Uvulectomy
Y <input type="checkbox"/>	N <input type="checkbox"/>	Gallbladder	Y <input type="checkbox"/>	N <input type="checkbox"/>	Nasal	Y <input type="checkbox"/>	N <input type="checkbox"/>	Periodontal

Other \_\_\_\_\_

**FAMILY HISTORY** Please indicate which of the follow conditions a family member has had (parent, sibling or grandparent)

Y <input type="checkbox"/>	N <input type="checkbox"/>	Cancer	Y <input type="checkbox"/>	N <input type="checkbox"/>	Asthma/COPD (Chronic Obstructive Pulmonary Disease)	Y <input type="checkbox"/>	N <input type="checkbox"/>	Mother snores
Y <input type="checkbox"/>	N <input type="checkbox"/>	Heart disease	Y <input type="checkbox"/>	N <input type="checkbox"/>	Sleep disorder	Y <input type="checkbox"/>	N <input type="checkbox"/>	Father has sleep apnea
Y <input type="checkbox"/>	N <input type="checkbox"/>	Diabetes	Y <input type="checkbox"/>	N <input type="checkbox"/>	Obesity	Y <input type="checkbox"/>	N <input type="checkbox"/>	Mother has sleep apnea
Y <input type="checkbox"/>	N <input type="checkbox"/>	High blood pressure	Y <input type="checkbox"/>	N <input type="checkbox"/>	Thyroid trouble			
Y <input type="checkbox"/>	N <input type="checkbox"/>	Stroke	Y <input type="checkbox"/>	N <input type="checkbox"/>	Father snores			

Other \_\_\_\_\_

**SOCIAL HISTORY:**

**Tobacco Use:** Cigarettes  Never smoked  Current smoker  Quit

When did you quit? \_\_\_\_\_

# packs per day \_\_\_\_\_  
# 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 # cups per day: \_\_\_\_\_

**Additional:**

Y <input type="checkbox"/>	N <input type="checkbox"/>	Regular exercise	Y <input type="checkbox"/>	N <input type="checkbox"/>	Perfectionist
Y <input type="checkbox"/>	N <input type="checkbox"/>	Depressed after work	Y <input type="checkbox"/>	N <input type="checkbox"/>	Psychological care
Y <input type="checkbox"/>	N <input type="checkbox"/>	Memory loss	Y <input type="checkbox"/>	N <input type="checkbox"/>	Schizophrenia
Y <input type="checkbox"/>	N <input type="checkbox"/>	Moody often	Y <input type="checkbox"/>	N <input type="checkbox"/>	Learning disability
Y <input type="checkbox"/>	N <input type="checkbox"/>	Emotional upsets	Y <input type="checkbox"/>	N <input type="checkbox"/>	Mental retardation
Y <input type="checkbox"/>	N <input type="checkbox"/>	Nervous breakdown	Y <input type="checkbox"/>	N <input type="checkbox"/>	Hyperactivity
Y <input type="checkbox"/>	N <input type="checkbox"/>	Nervousness	Y <input type="checkbox"/>	N <input type="checkbox"/>	Epilepsy
Y <input type="checkbox"/>	N <input type="checkbox"/>	Lose temper easily	Y <input type="checkbox"/>	N <input type="checkbox"/>	Drug problems