

# MEDICAL HISTORY QUESTIONNAIRE



Patient Name

Last	First	MI
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Birthdate

If "Yes," please list question # and explain

	No	Yes
1. In any pain or discomfort?	<input type="checkbox"/>	<input type="checkbox"/>
2. Lost any teeth prematurely?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever had any injuries to the mouth?	<input type="checkbox"/>	<input type="checkbox"/>
4. Any unusual speech/breathing habits?	<input type="checkbox"/>	<input type="checkbox"/>
5. Any mouth habits (thumb sucking, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
6. Pregnant or nursing a baby?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever had any unhappy dental visits?	<input type="checkbox"/>	<input type="checkbox"/>
8. Using tobacco in any form?	<input type="checkbox"/>	<input type="checkbox"/>
9. Taking any medications/drugs?	<input type="checkbox"/>	<input type="checkbox"/>
10. Allergic to any substances?	<input type="checkbox"/>	<input type="checkbox"/>

Date of last dental visit	<input type="text"/>	Reason for last visit	<input type="text"/>
Previous dentist's name	<input type="text"/>	Address	<input type="text"/>
Why did you not return to your previous dentist?	<input type="text"/>		
Physician's name	<input type="text"/>	Address	<input type="text"/>
List any physician's care within the last 3 years:	<input type="text"/>		
<input type="text"/>			
<input type="text"/>			

Is your home water fluoridated?	<input type="checkbox"/>	No	<input type="checkbox"/>	Yes
Do you drink soda (pop)?	<input type="checkbox"/>	<input type="checkbox"/>	How much?	<input type="text"/>
			How often?	<input type="text"/>
For ADULTS ONLY –				
How often do you brush?	<input type="text"/>	How often do you floss?	<input type="text"/>	
For MINORS ONLY –				
How often does your child brush?	<input type="text"/>	How often does your child floss?	<input type="text"/>	
Do you help your child brush?	<input type="checkbox"/>	<input type="checkbox"/>	If "Yes" →	How often do you help? <input type="text"/>
Do you help your child floss?	<input type="checkbox"/>	<input type="checkbox"/>	If "Yes" →	How often do you help? <input type="text"/>

PLEASE CHECK IF ANY OF THE FOLLOWING CONDITIONS ARE OR HAVE EVER BEEN APPLICABLE:

<input type="checkbox"/> Chest Pains	<input type="checkbox"/> AIDS (HIV)	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Congenital Heart Lesion	<input type="checkbox"/> Anemia	<input type="checkbox"/> Hepatitis A (Infectious)	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/> Hand/Feet/Ankle Swelling	<input type="checkbox"/> Blood Transfusions	<input type="checkbox"/> Hepatitis B (serum)	<input type="checkbox"/> Hypoglycemia
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Herpes	<input type="checkbox"/> Kidney Trouble
<input type="checkbox"/> Heart Pacemaker	<input type="checkbox"/> Cold Sores	<input type="checkbox"/> Prolonged Bleeding	
<input type="checkbox"/> Heart Surgery	<input type="checkbox"/> Fever Blisters	<input type="checkbox"/> Sickle Cell Anemia	<input type="checkbox"/> Alcoholism
<input type="checkbox"/> Heart Trouble			<input type="checkbox"/> Cancer
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Allergies/Hay Fever	<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Chemo/Radiation Therapy
<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Asthma	<input type="checkbox"/> Anorexia/Bulimia	<input type="checkbox"/> X-ray/Cobalt Therapy
<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Cortisone Medication
<input type="checkbox"/> Stroke	<input type="checkbox"/> Fainting/Dizzy Spells	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Epilepsy/Seizures
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Frequent Coughing	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Recent Weight Loss	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Arthritis/Gout	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Strong Gag Reflex	<input type="checkbox"/> Yellow Jaundice
<input type="checkbox"/> Pain in Jaw Joints	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Taken Fen-Phen or Redux	<input type="checkbox"/> Parathyroid Disease
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Skin Rashes/Hives	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Rheumatism	<input type="checkbox"/> Tuberculosis		<input type="checkbox"/> Venereal Disease

Please list all hospitalizations, surgeries or any other significant health problems not listed above:

<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>

Emergency Contact -- Name:  Tel. #

By signing below, I certify that this medical history accurately states all known conditions

Signature  Date