

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 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
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICAL HISTORY: (Please indicate dates on items marked current or 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"/>	_____	Infectious mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Acid reflux	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Injury to face/mouth/teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Adenoids Removed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Intestinal disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arteriosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Jaw joint surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Autoimmune disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Lung disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Backaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hormone problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood pressure - High	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Nasal allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood pressure - Low	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chest pains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
COPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Prior orthodontic treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Psychiatric care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<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"/>	_____

Patient Signature _____

Date _____

Medical condition	Never	Current	Past	If past, enter date
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Excessive thirst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fatigue easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fluid retention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart valve replacement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
General anesthesia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hand tremors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Immune system disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hearing impaired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Medical condition	Never	Current	Past	If past, enter date
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swallowing problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swollen, stiff or painful joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Muscle aches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Muscle spasms or cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tonsils Removed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tumors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neuralgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Polio	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Slow healing sores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swollen hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swelling in ankles or feet	<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
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

	Current	Past	
_____	<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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

	Never	Current	Past	If past, enter date
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

LIST ANY SURGICAL OPERATIONS YOU HAVE HAD:

Y <input type="checkbox"/>	N <input type="checkbox"/>	Appendectomy
Y <input type="checkbox"/>	N <input type="checkbox"/>	Back
Y <input type="checkbox"/>	N <input type="checkbox"/>	Ear
Y <input type="checkbox"/>	N <input type="checkbox"/>	Gallbladder

Y <input type="checkbox"/>	N <input type="checkbox"/>	Heart
Y <input type="checkbox"/>	N <input type="checkbox"/>	Hernia repair
Y <input type="checkbox"/>	N <input type="checkbox"/>	Lung
Y <input type="checkbox"/>	N <input type="checkbox"/>	Nasal

Y <input type="checkbox"/>	N <input type="checkbox"/>	Thyroid
Y <input type="checkbox"/>	N <input type="checkbox"/>	Tonsillectomy
Y <input type="checkbox"/>	N <input type="checkbox"/>	Uvulectomy
Y <input type="checkbox"/>	N <input type="checkbox"/>	Periodontal

Other _____

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

Y <input type="checkbox"/>	N <input type="checkbox"/>	Cancer
Y <input type="checkbox"/>	N <input type="checkbox"/>	Heart disease
Y <input type="checkbox"/>	N <input type="checkbox"/>	Diabetes
Y <input type="checkbox"/>	N <input type="checkbox"/>	High blood pressure

Y <input type="checkbox"/>	N <input type="checkbox"/>	Stroke
Y <input type="checkbox"/>	N <input type="checkbox"/>	Sleep disorder
Y <input type="checkbox"/>	N <input type="checkbox"/>	Obesity
Y <input type="checkbox"/>	N <input type="checkbox"/>	Thyroid trouble

Y <input type="checkbox"/>	N <input type="checkbox"/>	Father snores
Y <input type="checkbox"/>	N <input type="checkbox"/>	Mother snores
Y <input type="checkbox"/>	N <input type="checkbox"/>	Father has sleep apnea
Y <input type="checkbox"/>	N <input type="checkbox"/>	Mother has sleep apnea

Other _____

SOCIAL HISTORY:

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:

Y N

Y N