



MEDICAL HISTORY QUESTIONNAIRE

Please answer all questions to the best of your abilities. Extra space is provided on the second page. Thank you.

Date: _____ Name: _____ Male Female

Height: _____ Weight: _____ DOB: _____ Age: _____

Tell us why you came to the doctor today. _____

Do you have mouth, face, head or neck pain? YES NO How long? _____

Where? _____

ALLERGIES TO:

- 1) Latex YES NO
- 2) Penicillin YES NO
- 3) Demerol, fentanyl, codeine hydrocodone, or other narcotics? YES NO

- 4) Novocaine, lidocaine, or other local anesthetics? YES NO
- 5) Please list any other medication allergies or other allergies: _____

HAVE YOU EVER:

1) Had any operations or surgery? YES NO Describe/list: _____

2) Been admitted to a hospital? YES NO Describe: _____

3) Had implanted joints, devices, plates, or screws? YES NO Describe: _____

ILLNESSES:

- 1) Eye problems YES NO
- 2) Glaucoma YES NO
- 3) Contact Lenses YES NO
- 4) Ear problems YES NO
- 5) Sinus trouble YES NO
- 6) Nasal obstruction YES NO
- 7) Dental problems YES NO
- 8) Heart trouble, CAD, or heart failure YES NO
- 9) Heart attack YES NO
- 10) Angina (chest pain) YES NO
- 11) Rheumatic fever YES NO
- 12) Heart murmur YES NO
- 13) Congenital heart disease YES NO
- 14) Heart surgery YES NO
- 15) Pacemaker YES NO
- 16) Heart stents YES NO
- 17) Abnormal heart beat YES NO
- 18) High blood pressure YES NO
- 19) Low blood pressure YES NO
- 20) High cholesterol or triglycerides YES NO
- 21) Shortness of breath YES NO
- 22) Lung problems YES NO
- 23) Emphysema YES NO
- 24) Asthma YES NO
- 25) Cough YES NO

- 26) GERD (acid reflux) YES NO
- 27) Ulcers YES NO
- 28) Liver disease YES NO
- 29) Hepatitis YES NO
- 30) Cirrhosis YES NO
- 31) Jaundice YES NO
- 32) Seizures or convulsions YES NO
- 33) Stroke or TIA YES NO
- 34) Anxiety YES NO
- 35) ADD/ADHD YES NO
- 36) Bipolar YES NO
- 37) Schizophrenic or schizoaffective YES NO
- 38) Prolonged bleeding YES NO
- 39) Frequent bruising YES NO
- 40) Frequent nosebleeds YES NO
- 41) Anemia YES NO
- 42) Dialysis YES NO
- 43) Kidney failure YES NO
- 44) Diabetes YES NO
- 45) Thyroid problems YES NO
- 46) Arthritis YES NO
- 47) Osteoporosis YES NO
- 48) Cancer or tumor YES NO
- 49) Radiation treatment (XRT) YES NO
- 50) Chemotherapy YES NO

ADDITIONAL QUESTIONS

- 1) If you have asthma, have you ever been treated in an ER, urgent care, or hospital for your asthma? YES NO N/A
- 2) If you have had cancer or a tumor, what kind was it? When was it? _____
- 3) Do you have "TMJ", "TMD", clicking or popping of jaw joint, pain near the ear, or difficulty opening your mouth? YES NO
- 4) Do you grind or clench your teeth? YES NO
- 5) Do you smoke or use smokeless tobacco? If so, how much? _____ YES NO
- 6) Do you drink alcohol? If so, how much? _____ YES NO
- 7) Do you use marijuana, cocaine, or other "recreational" drugs? Which ones? _____ YES NO
- 8) Do you have any history of alcohol or chemical dependency? YES NO
- 9) Are you on a special diet? Describe _____ YES NO
- 10) Have you ever had anesthesia or sedation? YES NO
- 11) Have you or your immediate family had any problems with anesthesia or sedation? YES NO

Describe: _____

- 12) Is there any reason to believe you may be immunosuppressed? Describe _____ YES NO
- 13) Do you have any autoimmune diseases (rheumatoid arthritis, lupus, Chrohn's, ulcerative colitis, psoriasis, etc)? YES NO

WOMEN ONLY

- 1) Are you pregnant, or is there ANY chance you may be pregnant? YES NO
- 2) Are you on birth control? What kind? _____ YES NO
- 3) Are you breast feeding? YES NO
- 4) Date of your last menstrual cycle? _____ N/A

MEDICATIONS

- 1) Do you take blood thinners such as aspirin, ASA, Plavix, clopidogrel, warfarin, Coumadin, Xarelto, rivaroxaban, Pradax, dabigatiran, Aggrenox, dipyridamole, Ticlid, ticlopidine, heparin, Lovenox, Eliquis, apixaban, or others? YES NO
- 2) Have you taken steroids within the last 3 months? YES NO
- 3) Have you ever taken bisphosphonates (Boniva, Fosamax, Actonel, Aredia, Zometa, Reclast, alendronate)? YES NO
- 4) Have you ever taken denosumab, Prolia, or Xgevia? YES NO
- 5) Have you ever taken bevacizumab or Avastin? YES NO
- 6) Do you take immunosuppressive drugs such as methotrexate, Plaquenil, Orencia, Remicade, Enbrel, or Humira? YES NO
- 7) Have you been told NOT to take NSAIDs, Tylenol, acetaminophen, Advil, ibuprofen, Aleve or similar drugs? YES NO

LIST ALL MEDICATIONS AND DOSAGES YOU ARE CURRENTLY TAKING

PLEASE LIST ANY ADDITIONAL ILLNESSES, COMMENTS, OR INFORMATION WE NEED TO KNOW

I understand the importance of a truthful and complete Health History and realize that my incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information provided is complete and accurate.

Signature _____ Date _____

Print name and relationship if you are not the patient _____

Reviewed by _____ (doctor) Date _____