

MEDICAL HISTORY – QUESTIONNAIRE

To be completed by patient

What is your primary complaint today? What is the reason for your visit?

Have you ever had or do you currently have any of the following:

- 1) High Blood Pressure? Yes / No
 - 2) Heart Disease? Yes / No - Type: _____
 - 3) Diabetes? Yes / No - List relatives with it: _____
 - 4) Ulcer? Yes / No - Is the condition healed?: _____
Bleeding ulcer?: _____
 - 5) Pneumonia? Yes / No - What year: _____
 - 6) Hepatitis? Yes / No - List type: _____
 - 7) Asthma? Yes / No - List treatment: _____
 - 8) Scarlet Fever? Yes / No
 - 9) Rheumatic Fever? Yes / No
 - 10) Cancer? Yes / No - List type: _____
 - 11) Tuberculosis? Yes / No
 - 12) _____
- Other: _____
- _____
- _____

Please list all of the **medicines** that you are currently taking. If possible, list the name and dose of the medicine. Please indicate the name of the doctor prescribing it. Attach a list if necessary.

- 1) _____ 7) _____
- 2) _____ 8) _____
- 3) _____ 9) _____
- 4) _____ 10) _____
- 5) _____ 11) _____
- 6) _____ 12) _____

Do you have any medication allergies? Please list.

- 1) _____
- 2) _____
- 3) _____

Please list all **surgeries** that you have had in your lifetime. Please indicate the approximate year that the surgery was performed.

- 1) _____
- 2) _____
- 3) _____
- 4) _____

Do you use tobacco? Yes / No - Smoke or Chew How much, how often? _____
 If you have quit smoking, indicate how long ago and how much you smoked _____
 Caffeine intake, including soda, tea, coffee: _____
 Alcohol intake: please circle: daily / weekly / monthly / rarely / never
 Do you have dentures? Yes / No Full / partial / uppers / lowers
 Are you currently undergoing any dental treatment? _____

Patient Name (please print) _____ Date: _____