Medical History Questionnaire

Date _____

Patient Name _____ DOB _____

Chief complaint
(Please give a statement describing the symptom(s), problem(s), and reason(s) for the visit)

_____

_____

History of Present Illness

Location of symptoms (example: left upper jaw) _____

Description of pain: ☐ Aching ☐ Burning ☐ Radiating ☐ Sharp ☐ Throbbing

Pain severity on a scale of 1 to 10 (please circle): (no pain)-**1 2 3 4 5 6 7 8 9 10** -(severe pain)

Pain frequency: ☐ Constant ☐ Comes and goes ☐ Occasionally

How long did symptoms start: (example: started 3 days ago) _____

How did symptoms start: _____

What makes symptoms feel better: (example: better when heat is applied) _____

_____

Associated signs and symptoms (example: fever, chills, headaches, swelling, weight change) _____

_____

Please answer (circle):

1. Do your teeth bother you? **Yes** **No**

2. Do you have any jaw pain and/or numbness? **Yes** **No**

3. Do you have problems chewing? **Yes** **No**

If yes, please explain: ☐ Choking due to incomplete mastication

☐ Difficulty swallowing chewed solid food

☐ Ability to chew only soft or liquid food

How long have you had problems chewing? _____

4. Do you suffer from dry mouth or lack of saliva? **Yes** **No**

Have you ever had radiation to your head/neck area? **Yes** **No**

Have you ever had chemotherapy for cancer treatment? **Yes** **No**

5. Do you suffer from heartburn? **Yes** **No**

Have you ever been diagnosed with **GERD**? **Yes** **No**

Have you ever been diagnosed with a stomach ulcer? **Yes** **No**

Extremities

Prosthetic Joints	**Yes**	**No**	Varicose Veins	**Yes**	**No**

Eyes

Blurring Vision	**Yes**	**No**	Double Vision	**Yes**	**No**
Drooping Eyelid	**Yes**	**No**	Glaucoma	**Yes**	**No**

Ear, Nose and Throat

Earache	**Yes**	**No**	Hearing Loss	**Yes**	**No**
Frequent Nosebleeds	**Yes**	**No**	Sinusitis	**Yes**	**No**
Frequent Sore Throat	**Yes**	**No**	Hoarseness	**Yes**	**No**

Respiratory

Cough, Blood in Sputum	**Yes**	**No**	Emphysema	**Yes**	**No**
Asthma, Wheezing	**Yes**	**No**	Tuberculosis	**Yes**	**No**

Cardiac

Shortness of Breath	**Yes**	**No**	Pain/Pressure in Chest	**Yes**	**No**
Swelling of Ankles	**Yes**	**No**	High/Low Blood Pressure	**Yes**	**No**
Rheumatic, Scarlet Fever	**Yes**	**No**	Heart Murmur/Attack	**Yes**	**No**
Prosthetic Valves	**Yes**	**No**	Pacemaker	**Yes**	**No**

Gastrointestinal

Difficulty Swallowing	**Yes**	**No**	Hepatitis, Jaundice	**Yes**	**No**

Hematopoietic

Bruise Easily	**Yes**	**No**	Anemia	**Yes**	**No**
HIV/Aids	**Yes**	**No**	Immune System Problems	**Yes**	**No**

Psychiatric

Nervousness	**Yes**	**No**	Depression	**Yes**	**No**

Social History

Tobacco use	**Yes**	**No**	**Type:** ☐ Cigarettes ☐ Chewing tobacco ☐ Pipe How much? _____ per Day / Week / Month
Alcohol use	**Yes**	**No**	How many drinks? _____ per Day / Week / Month
Recreational drug use	**Yes**	**No**	If yes, specify _____ How much? _____ per Day / Week / Month

Additional Comments

_____

_____

_____

_____

_____

I certify that any and all questions I had about the inquires above have been answered to my satisfaction. I was asked all of the questions on this form and I have answered these questions truthfully and completely. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made.

_____

Date **Patient Signature** **Signature of Guardian (if applicable)**

_____

Date **Signature of Provider**