Medical History Questionnaire

OFFICE USE
Patient ID: __________

NAME: ____
First *Middle Initial* *Last*

FORM DATE: __/__/____

DATE OF BIRTH: __________

This questionnaire was designed to provide important facts regardng the history of your pain or condition. The information you provide will assist in reaching a diagnosis and determining the source of your problem. Please take your time and answer each question as completely and honestly as possible. Please sign each page.

LIST ANY MEDICATIONS/SUBSTANCES WHICH HAVE CAUSED AN ALLERGIC REACTION:

Y	N	Substance	Y	N	Substance	Y	N	Substance
☐	☐	Antibiotics	☐	☐	Latex	☐	☐	Sedatives
☐	☐	Aspirin	☐	☐	Local anesthetics	☐	☐	Sleeping pills
☐	☐	Barbiturates	☐	☐	Metals	☐	☐	Sulfa drugs
☐	☐	Codeine	☐	☐	Penicillin			
☐	☐	Iodine	☐	☐	Plastic			

Other ____________________ ____________________ ____________________

LIST ANY MEDICATIONS CURRENTLY BEING TAKEN:

Medication name	Dosage/ Frequency	Reason

Other Items: ____________________ ____________________

MEDICAL HISTORY: (Please indicate dates on items marked past)

Medical condition	Never	Current	Past	If past, enter date
Acid reflux (GERD)	☐	☐	☐	
AIDS	☐	☐	☐	
Allergies	☐	☐	☐	
Anemia	☐	☐	☐	
Arteriosclerosis	☐	☐	☐	
Asthma	☐	☐	☐	
Bleeding easily	☐	☐	☐	
Blood pressure - High	☐	☐	☐	
Blood pressure - Low	☐	☐	☐	
Bruising easily	☐	☐	☐	
Cancer	☐	☐	☐	
Chemotherapy	☐	☐	☐	
Chest pains	☐	☐	☐	
Choking or gasping for air while sleeping	☐	☐	☐	
Chronic cough	☐	☐	☐	
Chronic fatigue	☐	☐	☐	
Chronic pain	☐	☐	☐	
Cold sores	☐	☐	☐	
Concussion	☐	☐	☐	

Medical condition	Never	Current	Past	If past, enter date
HIV positive	☐	☐	☐	
Hyperlipidemia	☐	☐	☐	
Hypoglycemia	☐	☐	☐	
Hypothyroid	☐	☐	☐	
Infectious mononucleosis	☐	☐	☐	
Insomnia	☐	☐	☐	
Intestinal disorders	☐	☐	☐	
Kidney problems	☐	☐	☐	
Liver disease	☐	☐	☐	
Lung disease	☐	☐	☐	
Lupus	☐	☐	☐	
Meniere's disease	☐	☐	☐	
Mitral valve prolapse	☐	☐	☐	
Multiple sclerosis	☐	☐	☐	
Muscle shaking (tremors)	☐	☐	☐	
Muscular dystrophy	☐	☐	☐	
Needing extra pillows to help breathing at night	☐	☐	☐	
Nervous system irritability	☐	☐	☐	
Neuralgia	☐	☐	☐	

Patient Signature ______________________________ Date ____________________

Medical condition	Never	Current	Past	If past, enter date
COPD-chronic obstructive pulmonary disease	☐	☐	☐	____________
Current pregnancy	☐	☐	☐	____________
Depression	☐	☐	☐	____________
Diabetes	☐	☐	☐	____________
Difficulty concentrating	☐	☐	☐	____________
Difficulty sleeping	☐	☐	☐	____________
Dizziness	☐	☐	☐	____________
Emphysema	☐	☐	☐	____________
Epilepsy	☐	☐	☐	____________
Excessive daytime sleepiness (EDS)	☐	☐	☐	____________
Excessive thirst	☐	☐	☐	____________
Fainting spells	☐	☐	☐	____________
Fast pulse	☐	☐	☐	____________
Fatigue easily	☐	☐	☐	____________
Fibromyalgia	☐	☐	☐	____________
Fluid retention	☐	☐	☐	____________
Frequent urination	☐	☐	☐	____________
Gall bladder problems	☐	☐	☐	____________
Glaucoma	☐	☐	☐	____________
Gout	☐	☐	☐	____________
Hand tremors	☐	☐	☐	____________
Hay fever	☐	☐	☐	____________
Headaches-Cluster	☐	☐	☐	____________
Headaches-Migraine	☐	☐	☐	____________
Headaches--Morning	☐	☐	☐	____________
Headaches-Sinus	☐	☐	☐	____________
Hearing impaired	☐	☐	☐	____________
Heart-atrial fibrillation	☐	☐	☐	____________
Heart attack	☐	☐	☐	____________
Heartburn	☐	☐	☐	____________
Heart murmur w/o valvular regurgitation	☐	☐	☐	____________
Heart murmur w/valvular regurgitation	☐	☐	☐	____________
Heart pacemaker	☐	☐	☐	____________
Heart palpitations	☐	☐	☐	____________
Heart valve replacement	☐	☐	☐	____________
Hemophilia	☐	☐	☐	____________
Hepatitis	☐	☐	☐	____________

Medical condition	Never	Current	Past	If past, enter date
Osteoarthritis	☐	☐	☐	____________
Osteoporosis	☐	☐	☐	____________
Parkinson's disease	☐	☐	☐	____________
Pneumonia	☐	☐	☐	____________
Polio	☐	☐	☐	____________
Prior orthodontic treatment	☐	☐	☐	____________
Prostate problems	☐	☐	☐	____________
Psychiatric care	☐	☐	☐	____________
Radiation treatment	☐	☐	☐	____________
Reactions to lead/mercury	☐	☐	☐	____________
Restless Legs Syndrome	☐	☐	☐	____________
Rheumatic fever	☐	☐	☐	____________
Rheumatoid arthritis	☐	☐	☐	____________
Scarlet fever	☐	☐	☐	____________
Scoliosis	☐	☐	☐	____________
Shortness of breath	☐	☐	☐	____________
Sinus problems	☐	☐	☐	____________
Sleep-Bruxism (grinding / clenching of teeth)	☐	☐	☐	____________
Sleep-Snoring	☐	☐	☐	____________
Sleep-UARS (upper airway resistance syndrome)	☐	☐	☐	____________
Sleep-OSA (obstructive sleep apnea)	☐	☐	☐	____________
Sleep-CSA (central sleep apnea)	☐	☐	☐	____________
Sleep-Complex Sleep Apnea	☐	☐	☐	____________
Stroke	☐	☐	☐	____________
Swelling in ankles or feet	☐	☐	☐	____________
Teeth grinding /clenching	☐	☐	☐	____________
Thyroid disorder	☐	☐	☐	____________
TMJ (jaw joint) issues	☐	☐	☐	____________
TMJ (jaw joint) surgery	☐	☐	☐	____________
Tonsils Removed	☐	☐	☐	____________
Tuberculosis	☐	☐	☐	____________
Tumors	☐	☐	☐	____________
Ulcers	☐	☐	☐	____________
Urinary disorders	☐	☐	☐	____________
Valley Fever	☐	☐	☐	____________
Wisdom teeth extraction	☐	☐	☐	____________
______________	☐	☐	☐	____________

Other	Current	Past	If past, enter date		Current	Past	If past, enter date
________________________	☐	☐	____________	________________________	☐	☐	____________
________________________	☐	☐	____________	________________________	☐	☐	____________
________________________	☐	☐	____________	________________________	☐	☐	____________

MEDICAL HISTORY

Other ____________________ ____________________

Patient Signature ________________________________ Date ____________________

ADDITIONAL MEDICAL HISTORY ITEMS:

	Never	Current	Past	If past, enter date
HIV/AIDS	☐	☐	☐	____________
Recreational drugs	☐	☐	☐	____________

LIST ANY SURGICAL OPERATIONS YOU HAVE HAD:

Y	N	Operation	Y	N	Operation	Y	N	Operation
☐	☐	Appendectomy	☐	☐	Heart	☐	☐	Sinus
☐	☐	Back (Spine)	☐	☐	Hernia repair	☐	☐	Thyroid
☐	☐	Cosmetic surgery	☐	☐	Knee replacement	☐	☐	Tonsillectomy
☐	☐	Ear	☐	☐	Lung	☐	☐	UPPP (Uvulopalatopharyngoplasty)
☐	☐	Eye	☐	☐	Nasal	☐	☐	Uvulectomy
☐	☐	Gallbladder	☐	☐	Periodontal (Gum)			

Other ____________________ ____________________ ____________________

____________________ ____________________ ____________________

FAMILY HISTORY

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

__Yes __No Asthma
__Yes __No Cancer
__Yes __No COPD (Chronic Obstructive Pulmonary Disease)
__Yes __No Diabetes
__Yes __No Father snores
__Yes __No Mother snores
__Yes __No Father has sleep apnea
__Yes __No Mother has sleep apnea
__Yes __No Heart disease
__Yes __No High blood pressure
__Yes __No Obesity
__Yes __No Sleep disorder
__Yes __No Stroke
__Yes __No Thyroid trouble

SOCIAL HISTORY:

Patient's Occupation ________________ Employer ________________

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:

LIST OF ALL CURRENT DOCTORS
(name/type of Dr/address/phone)

1. Primary Care Physician (PCP):
2. Sleep Physician
3. Regular Dentist

I authorize the release of a full report of examination findings, diagnosis, treatment program etc., to any referring or treating dentist or physician. I additionally authorize the release of any medical information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all charges for treatment to me regardless of insurance coverage.

Patient Signature ______________________________ Date ______________

I certify that the medical history information is complete and accurate.

Patient Signature ______________________________ Date ______________

Patient Signature ______________________________ Date ______________