JEFF L. RODGERS, DMD * D ABDSM * D ASBA

Medical History Questionnaire

NAME: ______________________________

FORM DATE: ____/____/_______

DATE OF BIRTH: ___/___/______

Allergens

- ☐ No known allergens
- ☐ Antibiotics
- ☐ Aspirin
- ☐ Barbiturates
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local anesthetics
- ☐ Metals
- ☐ Penicillin
- ☐ Plastic
- ☐ Sedatives
- ☐ Sleeping pills
- ☐ Sulfa drugs

______________________ ______________________

Current Medications

Medicine	Dosage/Frequency	Reason

Other

Medical History

Significant Medical Condition	Y/N/Past	Date / Note	Significant Medical Condition	Y/N/Past	Date / Note
☐ Acid reflux	☐ ☐ ☐		☐ COPD	☐ ☐ ☐	
☐ Anemia	☐ ☐ ☐		☐ Coronary heart disease	☐ ☐ ☐	
☐ Atherosclerosis	☐ ☐ ☐		☐ Current pregnancy	☐ ☐ ☐	
☐ Arthritis	☐ ☐ ☐		☐ Depression	☐ ☐ ☐	

	Significant Medical Condition	Y/N/Past	Date / Note		Significant Medical Condition	Y/N/Past	Date / Note
☐	Asthma	☐ ☐ ☐		☐	Diabetes	☐ ☐ ☐	
☐	Autoimmune disorder	☐ ☐ ☐		☐	Difficulty sleeping	☐ ☐ ☐	
☐	Bleeding easily	☐ ☐ ☐		☐	Dizziness	☐ ☐ ☐	
☐	Blood pressure - High	☐ ☐ ☐		☐	Emphysema	☐ ☐ ☐	
☐	Blood pressure - Low	☐ ☐ ☐		☐	Epilepsy	☐ ☐ ☐	
☐	Bruising easily	☐ ☐ ☐		☐	Excessive Daytime Sleepiness	☐ ☐ ☐	
☐	Cancer	☐ ☐ ☐		☐	Fibromyalgia	☐ ☐ ☐	
☐	Chemotherapy	☐ ☐ ☐		☐	Glaucoma	☐ ☐ ☐	
☐	Chronic fatigue	☐ ☐ ☐		☐	Gout	☐ ☐ ☐	
☐	Chronic pain	☐ ☐ ☐		☐	Heart attack	☐ ☐ ☐	

Medical History

	Significant Medical Condition	Y/N/Past	Date / Note		Significant Medical Condition	Y/N/Past	Date / Note
☐	Heart murmur	☐ ☐ ☐		☐	Nasal allergies	☐ ☐ ☐	
☐	Heart pacemaker	☐ ☐ ☐		☐	Neuralgia	☐ ☐ ☐	
☐	Heart valve replacement	☐ ☐ ☐		☐	Osteoarthritis	☐ ☐ ☐	
☐	Hemophilia	☐ ☐ ☐		☐	Osteoporosis	☐ ☐ ☐	
☐	Hepatitis	☐ ☐ ☐		☐	Parkinson's disease	☐ ☐ ☐	
☐	Hypertension	☐ ☐ ☐		☐	Prior orthodontic treatment	☐ ☐ ☐	
☐	Hypoglycemia	☐ ☐ ☐		☐	Radiation treatment	☐ ☐ ☐	
☐	Immune system disorder	☐ ☐ ☐		☐	Rheumatic fever	☐ ☐ ☐	
☐	Insomnia	☐ ☐ ☐		☐	Rheumatoid arthritis	☐ ☐ ☐	
☐	Ischemic heart disease (reduced blood supply)	☐ ☐ ☐		☐	Sinus problems	☐ ☐ ☐	
☐	Kidney problems	☐ ☐ ☐		☐	Sleep apnea	☐ ☐ ☐	
☐	Liver disease	☐ ☐ ☐		☐	Stroke	☐ ☐ ☐	
☐	Meniere's disease	☐ ☐ ☐		☐	Tendency for ear infections	☐ ☐ ☐	
☐	☐ Mitral valve prolapse	☐ ☐ ☐		☐	Thyroid disorder	☐ ☐ ☐	
	Mood disorder	☐ ☐ ☐		☐	Tuberculosis	☐ ☐ ☐	

	Medical Condition	Current	Past		Date / Note		Medical Condition	Current	Past		Date / Note
☐	Multiple sclerosis	☐	☐	☐		☐	Tumors	☐	☐	☐	
☐	Muscular dystrophy	☐	☐	☐		☐	Urinary disorders	☐	☐	☐	

Other

	Medical Condition	Current	Past	Date / Note		Medical Condition	Current	Past	Date / Note
☐		☐	☐		☐		☐	☐	

Medical History

Please list any other health professionals are you currently seeing:

Primary Care Physician

Primary Care Physician Name: __________

Primary Care Physician Phone/Address: __________

Sleep Physician

Sleep Physician Name: __________

Sleep Physician Phone/Address: __________

Pulmonologist

Pulmonologist Name: __________

Pulmonologist Phone/Address: __________

Cardiologist

Cardiologist Name: __________

Cardiologist Phone/Address: __________

Regular Dentist

Dentist Name: __________

Dentist Phone/Address: __________

Other

Any other health professionals you currently see: __________

Medical History

Other

___________ ___________

Confidential Medical History

Significant	Medical Condition	Current	Never	Past	Date / Note
☐	Recreational drugs	☐	☐	☐	________
☐	HIV/AIDS	☐	☐	☐	________

Surgical Operations

☐ Appendectomy ☐ Heart ☐ Thyroid
☐ Back ☐ Hernia repair ☐ Tonsillectomy
☐ Ear ☐ Lung ☐ Uvulectomy
☐ Gallbladder ☐ Nasal ☐ Periodontal

Other

___________ ___________ ___________

Family History

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

☐ Cancer ☐ Stroke ☐ Father snores
☐ Heart disease ☐ Sleep disorder ☐ Mother snores
☐ Diabetes ☐ Obesity ☐ Father has sleep apnea
☐ High blood pressure ☐ Thyroid disorder ☐ Mother has sleep apnea

Social History

Patient's Occupation ___________ Employer ___________

Tobacco Use: Cigarettes ☐ Never smoked ☐ Current smoker ☐ Quit

# of packs per day ____

# of years ____

When did you quit? ________

Other tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Alcohol Use: Do you drink alcohol? ☐ Yes ☐ No If yes, # of drinks per week: ____

Caffeine Intake: ☐ None ☐ Coffee/Tea/Soda # of cups per day: ____

Additional:

☐ Regular exercise

Patient Signature

Because of HIPAA Federal regulations protecting your privacy, we wish to inform you that we will release no information about you without your consent. By agreeing to this consent, you permit the release of any information to or from your dental practitioner as required including a full report of examination findings, diagnosis and treatment program to any referring or treating dentist or physician. You understand that you are financially responsible for all charges whether or not paid by insurance. Your dental practitioner may use your health care information and may disclose such information to your Insurance Company(ies) and their agents for the purpose of obtaining payment for service and determining insurance benefits or the benefits payable for related services.

Patient Signature: ________________________________ Date: ________________

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

Patient Signature: ________________________________ Date: ________________