RENEW DENTAL

MEDICAL HISTORY QUESTIONNAIRE

Name: _____Date:_____

Date of Birth: _____ Sex ___M ___F Home Phone: (_____)_____

Address: _____ Business Phone: (____)_____

City: _____ State: _____ Zip Code: _____ Mobile Phone: (_____)_____

Name of Spouse/Partner: _____

Emergency Contact: _____Phone of Contact: _____

Whom may we thank for referring you? _____

PART I: MEDICAL HISTORY:

1. Are you now, or have you been in the 12 past months, under the care of a physician? **Y** N
For what reason? _____ Last medical appointment date_____
Name of physician: _____ Phone no: _____

2. Do you have any allergies or sensitivities that you know of? **Y** N **If yes, state here: _____**

3. List (or attach a list) any PRESCRIPTION OR OVER THE COUNTER MEDICATIONS that you are taking at the present time:
_____

4. Are you pregnant? **Y** N Are you taking oral contraceptives? **Y** N

5. Chief complaint today _____
Have you been treated for this previously? **Y** N **If yes, how long ago? _____**
Type of previous treatment? ____Non-surgical ____ Surgical

REVIEW OF SYSTEMS:

i. SKIN Itching **Y** N Rash **Y** N Ulcers **Y** N Pigmentation **Y** N Lack or loss of body hair **Y** N History of Shingles **Y** N

ii. EXTREMITIES Varicose veins **Y** N Swollen/painful joints **Y** N Muscle weakness/pain **Y** N Bone deformity/fractures **Y** N Prosthetic joints **Y** N

iii. EYES Blurred vision **Y** N Double vision **Y** N Drooping eyelids **Y** N Glaucoma **Y** N

iv. EAR, NOSE, THROAT Earache **Y** N Hearing Loss **Y** N Frequent nosebleed **Y** N Sinusitis **Y** N Frequent sore throat **Y** N Hoarseness **Y** N Jaw joint pain **Y** N

v. RESPIRATORY Cough **Y** N Blood in sputum **Y** N Emphysema **Y** N Wheezing, asthma **Y** N
Tuberculosis, or exposure to TB **Y** N Lung transplant **Y** N

vi. CARDIAC Shortness of breath **Y** N Pain, pressure in chest **Y** N Swelling of ankles **Y** N
High/low blood pressure **Y** N Rheumatic or scarlet fever **Y** N Heart murmur **Y** N History of heart attack **Y** N Prosthetic valve **Y** N Pacemaker **Y** N Open heart surgery **Y** N Heart transplant **Y** N

vii. GASTROINTESTINAL Difficulty swallowing **Y** N Abdominal pain, ulcers **Y** N Heartburn **Y** N Hepatitis, jaundice **Y** N Liver disease **Y** N

viii. GENITOURINARY Difficulty/pain on urination **Y** N Blood in urine **Y** N Excessive urination **Y** N Kidney infections **Y** N Urinary tract infections **Y** N Sexually transmitted disease **Y** N

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ix. ENDOCRINE Thyroid issues **Y** N Weight change **Y** N Diabetes **Y** N Excessive thirst **Y** N

xi. NEUROLOGIC Frequent headaches **Y** N Dizziness, fainting **Y** N Epilepsy **Y** N Neuritis/neuralgia **Y** N Paresthesia/numbness **Y** N Paralysis **Y** N

xii. PSYCHIATRIC Nervousness **Y** N Anxiety **Y** N Depression **Y** N Nervous breakdown **Y** N Bi-polar disorder **Y** N

xiii. GROWTH OR TUMOR History of Tumor? **Y** N **If yes, type: _____**
When diagnosed? Date: _____ Benign or ___ **Malignant**
Treatment: ____ Radiation ____Chemotherapy ____Surgery
In remission? **Y** N If yes, for how long? _____
Reoccurrence? **Y** N **If yes, when: _____**
Current tumor status: _____

PART II: DENTAL HISTORY

1. Frequency of dental visits ___ Quarterly ___ Twice a year ___ Yearly ___ As needed
2. Problems with previous treatment? **Describe: _____**
3. Any adverse reactions to anesthetics, gloves, dental materials used? **Y** N **If yes, describe: _____**
4. Date of most recent complete X-rays: _____

PART III: FAMILY HISTORY

Have any members of your family ever been treated for the following conditions, or had any other medical problems not listed?
PLEASE CHECK ALL THAT APPLY: ___ Diabetes ___ High blood pressure ___ Heart problems ___ Cancer ___ Seizures ___ Mental disorder ___ HIV/AIDS Other: _____

PART IV: SOCIAL HISTORY

Tobacco use **Y** N **If yes, type ___ Cigarettes ___ Cigars ___ Chewing tobacco How often? _____**

Alcohol **Y** N **If yes, ___ Occasionally ___ Socially ___Frequently ___ Daily # of drinks _____**

Recreational drugs **Y** N **If yes, ___ Occasionally ___ Socially ___Frequently ___ Daily**

If the person completing the form is other than the patient, what is his/her relationship to the patient? _____

I certify that any and all questions that I had about the inquiries, above, have been answered to my satisfaction. 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 have made.

Signature of Patient: _____ Date signed: _____

Signature of Guardian (where applicable): _____ Date signed: _____

Additional comments on patient interview concerning medical history: _____

Significant finding from oral interview: _____

Patient management considerations: _____

Signature of Examining Doctor: _____