RENEW DENTAL

MEDICAL HISTORY QUESTIONNAIRE

Name:_____ **Date:**_____

Date of Birth:_____ **Sex:**_____**M**_____**F**

Whom may we thank for referring you?_____Home Phone: (___)_____

Address:_____ Mobile Phone: (_____)_____

City:_____State:_____Zip Code:_____Email:_____

Emergency Contact:_____**Phone of Contact:** _____

Relationship: Spouse – Friend – Family/Other: _____

Insurance: _____Social:_____Employer:_____

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** Rash **Y** Ulcers **Y** Pigmentation **Y** Lack or loss of body hair **Y** History of Shingles **Y** ☐ None to all (SKIN)

ii. EXTREMITIES Varicose veins **Y** Swollen/painful joints **Y** Muscle weakness/pain **Y**
Bone deformity/fractures **Y** Prostheticjoints **Y** ☐ None to all (EXTREMITIES)

iii. EYES Blurred vision **Y** Double vision **Y** Drooping eyelids **Y** Glaucoma **Y** ☐ None to all (EYES)

iv. EAR, NOSE, THROAT Earache **Y** Hearing Loss **Y** Frequent nosebleed **Y** Sinusitis **Y**
Frequent sore throat **Y** Hoarseness **Y** Jaw joint pain **Y** ☐ None to all(EARS,NOSE,THROAT)

v. RESPIRATORY Cough **Y** N Blood in sputum **Y** Emphysema **Y** Wheezing, asthma **Y**
Tuberculosis, or exposure to TB **Y** Lung transplant **Y** ☐ None to all (RESPIRATORY)

vi. CARDIAC Shortness of breath **Y** Pain, pressure in chest **Y** Swelling of ankles **Y**
High/low blood pressure **Y** Rheumatic or scarlet fever **Y** Heart murmur **Y** ☐ None to all (CARDIAC)
History of heart attack **Y** Prosthetic valve **Y** Pacemaker **Y** Open heart surgery **Y**
Heart transplant **Y** High Cholesterol **Y**

vii. GASTROINTESTINAL Difficulty swallowing **Y** Abdominal pain, ulcers **Y** Heartburn **Y**
Hepatitis, jaundice **Y** Liver disease **Y** ☐ None to all (GASTROINTESTINAL)

viii. GENITOURINARY Difficulty/pain on urination **Y** Blood in urine **Y** Excessive urination **Y**
Kidney infections **Y** Urinary tractinfections **Y** Sexually transmitted disease **Y** ☐ None to all (GENITOURINARY)

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Name:_____ **Date:**_____

Date of Birth:_____ **Sex:**_____**M**_____**F**

ix. ENDOCRINE Thyroid issues **Y** Weight change **Y** Diabetes **Y** Excessive thirst **Y** ☐ None to all (ENDOCRINE)

xi. NEUROLOGIC Frequent headaches **Y** Dizziness, fainting **Y** Epilepsy **Y**
Neuritis/neuralgia **Y** Paresthesia/numbness **Y** Paralysis **Y** ☐ None to all(NEUROLOGIC)

xii. PSYCHIATRIC Nervousness **Y** Anxiety **Y** Depression **Y** Nervous breakdown **Y** Bi-polar disorder **Y** ☐ None to all (PSYCHIATRIC)

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: _____