Medical History Questionnaire

Patient ID

Name_____ Preferred Name_____

Date of Birth_____ Pronoun: He She They Other: _____

Please answer the following questions as best you can. Your answers are confidential.

Have there been any changes to your general health within the last two years? Yes No

If yes, please explain: _____

Have you been hospitalized within the last two years due to illness or surgery? Yes No

If yes, please explain: _____

Do you have any artificial joints or heart valves? Yes No

If yes, what type, and when was your surgery: _____

Do you sleep well most nights? Yes No

If no, please explain: _____

Do you drink alcohol? Yes No

If yes, how many drinks per week on average? _____

Have you ever had a chemical dependency? Yes No

If you are in recovery, how long has it been? _____

Do you use tobacco or marijuana (smoking, chewing, vaping)? Yes No

Are you: pregnant / nursing / on birth control / none of these *(please circle any that apply to you)*

Primary care physician: _____ Date of last physical exam: _____

Preferred pharmacy name & town: _____

Do you currently have, or have you had the following? Check all that apply:

☐ Pre-med *(circle any that apply)*: Amoxicillin Clindamycin Other: _____

☐ Allergy *(circle any that apply)*: Amoxicillin Aspirin Cinnamon Clindamycin Codeine Demerol Epi Erythro Hay Fever Latex Metals Nut Penicillin Red Dye Sulfa Other: _____

☐ Acid Reflux
☐ Addiction
☐ Anemia
☐ Anorexia
☐ Anxiety/Panic Disorder/PTSD
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Autism
☐ Blindness
☐ Bloody Sputum
☐ Blood Disorder
☐ Blood Thinners
☐ Cancer
☐ Claustrophobia
☐ Crohn's
☐ Diabetes (type: _____)
☐ Dizziness
☐ Epilepsy
☐ Fainting
☐ Fever
☐ Fibromyalgia
☐ Glaucoma
☐ Hearing Loss
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis (A, B, or C: _____)
☐ High Blood Pressure
☐ HIV
☐ Kidney Disease
☐ Liver Disease
☐ Lyme Disease
☐ Mental Health Complication
☐ Mobility Problem
☐ Multiple Sclerosis
☐ Nervous Disorder
☐ Night Sweats
☐ Osteoporosis
☐ Pacemaker
☐ Persistent Cough
☐ Radiation
☐ Respiratory Problem
☐ Rheumatic Fever
☐ Seizures
☐ STD
☐ Sinus Problem
☐ Sleep Apnea
☐ Stomach Problem
☐ Stroke
☐ Thyroid Condition
☐ Tumor
☐ Ulcer
☐ Weight Loss
☐ Other: _____

CONTINUED ON NEXT PAGE

Current Medications – please fill out this section or provide a copy of your current med list

Medication / Vitamin / Birth Control	Dosage	Frequency	Reason

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I understand that providing inaccurate information has the potential to be hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs or other diagnostic aids deemed appropriate. Upon such diagnosis, I authorize doctor to perform all recommended and mutually agreed upon treatment and to employ such assistance as required to provide proper care.

I authorize release of any information including the diagnosis and records of treatment or examination for myself and my dependents to third-party insurance carriers, payers, and/or healthcare practitioners. I authorize payment from my insurance carrier to the dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding account balance that is not fully covered by my insurance, and I may be billed this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf and/or that of my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

Acknowledgement of receipt of Notice of Privacy Practices:
I have received a copy of this office's Notice of Privacy Practices and accept the terms. Please initial: _____

HIPAA:
I give permission for Fiddlehead to share information with the following individual(s) involved with my care or payment for care (for example, family members or friends who help with appointments, scheduling, treatment, finances, etc.):

_____

Patient/Responsible Party Signature _____ **Date:** _____

Relationship to patient: _____

Fiddlehead Family Dentistry

Revised 11/01/2023