Medical History Questionnaire

Review the questions below and answer the best that you can. You will review this form during your physical examination with the medical provider.

When did you last visit a medical provider and for what reason?

Who is your primary care physician (PCP)?

Review the conditions below. Circle the appropriate answer.

	Do you have a history of any of the following conditions?	Does anyone in your family have a history of any of the following conditions?	Please provide details for any YES answers.
Diabetes	No Yes	No Yes Unsure	
Heart disease	No Yes	No Yes Unsure	
History of stroke	No Yes	No Yes Unsure	
Lung disease	No Yes	No Yes Unsure	
Seizures	No Yes	No Yes Unsure	
Cancer	No Yes	No Yes Unsure	
Liver disease	No Yes	No Yes Unsure	
Kidney disease	No Yes	No Yes Unsure	
Hepatitis	No Yes	No Yes Unsure	
Thyroid disorder	No Yes	No Yes Unsure	
HIV/AIDS	No Yes	No Yes Unsure	

Do you have any allergies? ☐ No ☐ Yes | *If yes, explain:*

Do you have a history of chronic pain? ☐ No ☐ Yes | If yes, explain:

Do you have any history of head trauma? ☐ No ☐ Yes | If yes, explain:

Have you had any surgeries? ☐ No ☐ Yes | If yes, explain:

Have you ever overdosed? ☐ No ☐ Yes | If yes, explain:

Dental History

When was your last dental visit?

Do you have current dental needs? If yes, what are the barriers keeping you from meeting this need?

Current Medications

List all current medications, including over the counter medications and supplements.