AUGUSTA UNIVERSITY
DENTAL COLLEGE OF GEORGIA
CENTER FOR ORAL MEDICINE

MEDICAL HISTORY / HEALTH QUESTIONNAIRE

Patient Name:	**Date of Birth:**
Referring Doctor:	**Referring Doctor's Address:**
Primary Care Doctor:	**Primary Doctor's Address:**
Patient's Email address?	**Pharmacy Name and Phone Number:**
Reason for your visit today?	

PAIN ASSESSMENT:	**YES**	**NO**	
Are you having a problem with orofacial pain?			Where?
If yes, please circle your level of pain with 10 being the worst: **0 1 2 3 4 5 6 7 8 9 10**			

MEDICAL HISTORY: *To your knowledge, do you now have or have you had any of the following:*

RESPIRATORY PROBLEMS	**YES**	**NO**	**NEUROLOGICAL PROBLEMS**	**YES**	**NO**
Asthma			Stroke / TIA / Mini-Stroke		
Tuberculosis			Multiple sclerosis		
Sleep apnea			Epilepsy / Seizure disorder		
Bronchitis / Emphysema			Neuropathy / Neuropathic pain		
Other?			Other?		
HEMATOLOGIC PROBLEMS	**YES**	**NO**	**ENDOCRINE PROBLEMS**	**YES**	**NO**
Anemia			Diabetes		
Sickle cell disease / trait			Thyroid disorder		
HIV disease / AIDS			Other?		
Bleeding disorders			**OTHER PROBLEMS**	**YES**	**NO**
Coumadin / Warfarin treatment			Renal / Kidney disease or dialysis		
Other?			Organ transplant		
CARDIOVASCULAR PROBLEMS	**YES**	**NO**	Cancer		
High blood pressure / Hypertension			Radiation treatment		
Angina / Chest pain			Chemotherapy treatment		
Heart attack / Myocardial infarction			Arthritis		
Prosthetic (artificial) heart valve			Used a bisphosphonate medication for osteoporosis or cancer treatment		
Congestive heart failure			Psychiatric treatment		
Heart bypass or stent surgery			Other?		

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GASTROINTESTINAL PROBLEMS	YES	NO	ORAL MEDICINE PROBLEMS	YES	NO
Hepatitis / Jaundice			Dry mouth / Sjogren syndrome		
Liver disease			Mouth ulcers / sores		
GERD / Reflux / Ulcers			TMJ / Temporomandibular disorder		
Other?			Fibromyalgia		
Any other Health Concerns not listed?			Other?		

LIST OF CURRENT MEDICATIONS YOU TAKE	
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

ALLERGIES – MEDICATION NAME AND REACTION		
LIST OF SURGERIES	**Year?**	
1.		
2.		
3.		
4.		
LIST OF PERVIOUS ORAL BIOPSY?		

SOCIAL HISTORY To your knowledge, do you now or have you ever used any of the following?	YES	NO	
Cigarettes / Cigars / Pipes / Chewing Tobacco			Number of years?
Alcoholic beverages			How much per week?
Recreational drugs			What and how often?
For Women Only – Are you pregnant?			

FAMILY HISTORY	YES	NO	MEDICAL PROBLEMS / DISEASES
Mother alive?			
Father alive?			
Siblings alive?			
Children alive?			