BALTIMORE CITY COMMUNITY COLLEGE
MEDICAL HISTORY QUESTIONNAIRE

NAME: _____ PATIENT ID: _____

	Date:		Date:		Date:	
	Yes	No	Yes	No	Yes	No
1. Have you ever been hospitalized, had major operations, or a serious illness? If so, what?						
2. Are you under medical treatment now?						
3. Are you taking any prescribed or over-the-counter medicine or drugs including aspirin?						

CONDITION	MEDICATIONS/DOSE	CONTRAINDICATIONS	PDR CATEGORY

4. Have you had an allergic reaction to any drugs, including penicillin, codeine, and novocaine?						
5. Has there been a change in your health in the past year?						
6. Have you ever had a blood transfusion?						
7. When was the last time you gave blood?						
8. Have you ever had abnormal bleeding problems after a cut or tooth extraction?						
9. Have you ever had kidney dialysis treatment?						
10. Have you had any of the following diseases or problems?						
a. Heart Aliment						
b. Heart Murmur						
c. Mitral Valve Prolapse						
d. Angina						
e. Pacemaker						
f. Rheumatic Fever						
g. High Blood Pressure						
h. Stroke						
i. Blood Disease						
j. Coronavirus (Covid-19)						
k. Asthma						
l. Hepatitis						
m. Liver Disease						
n. Venereal Disease						
o. AIDS or HIV Positive						

p. Stomach or Intestinal Disease						
q. Kidney Disease						
r. Tumors/Growths/Radiation Therapy						
s. Diabetes						
t. Tuberculosis						
u. Respiratory Disease						
v. Epilepsy						
w. Thyroid Problems						
x. Alcohol or Drug Addiction						
y. Psychiatric Evaluation						
z. Prosthesis						
11. Women: Are you pregnant? Estimated date of delivery:						

12. Date of last X-rays: BW _____ FMS _____ PAN _____ Medical _____ Type _____

13. Vital Signs: B/P _____ Pulse _____ Resp _____

DENTAL HISTORY

1. Do you have any discomfort in your mouth now?						
2. When was your last dental visit?						
3. Do your gums bleed, feel tender or irritated?						
4. Are your teeth sensitive to hot/cold/sweets?						
5. Dose food wedge between certain teeth?						
6. Are any teeth loose?						
7. Do you grind, clench, or grit your teeth?						
8. Does your jaw ever click, or cause pain on opening or closing?						
9. Have you ever had any teeth extracted?						
10. If yes, have they been replaced?						
11. Have you ever worn braces?						
12. Have you ever worn any other dental appliances?						
13. Have you ever had a root canal?						
14. Have you ever had gum treatment?						
15. Do you wear dentures?						
16. Do you have an unpleasant taste in your mouth?						
17. Do you floss your teeth?						
18. What type of toothbrush do you use? Hard: Soft: Electric:						
19. Do you use any other aid for your teeth?						
20. Do you smoke or use smokeless tobacco?						

Name of Dentist _____ Phone No. _____

Name of Physician _____ Phone No. _____

Emergency Contact: _____ Phone No. _____