DEBORAH BARCKHAUSEN DMD MC PLLC
Jasmine Professional Park
7668 SW 60th Ave., Suite #300
Ocala, FL 34471
352.629.7878

MEDICAL HISTORY QUESTIONNAIRE

PATIENT INFORMATION

Date _____

Patient's Name _____
First Middle Last Pref. Name

Home Address _____
Street City State Zip

Home Phone _____ Birthdate _____

Email _____ Facebook name(optional)_____

Friends or relative in treatment with us_____

Name and age of siblings _____

RESPONSIBLE PARTY INFORMATION

Parent's Name _____
First Middle Last

Home Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Email Address _____ Employer _____

Spouse's Name _____
First Middle Last

Social Security # _____ Birthdate _____ Relationship to Patient _____

Email Address _____ Employer _____

DENTAL INFORMATION

Family Dentist _____

Address _____
Street City State Zip

Date of last dental checkup _____

Whom may we thank for referring you? _____

DENTAL INSURANCE INFORMATION

Insured's Name _____ Insured's Employer_____

Insurance Company _____ Insured's ID # _____Group No. _____

Insurance Co. Address _____
Street City State Zip

Do you have dual coverage: Yes No If yes: _____

Insured's Name_____ Insured"s Employer_____

Insurance Company _____ Insured's ID # _____ Group No. _____

Insurance Co. Address _____
Street City State Zip

Signature (Parent's signature if minor) _____

(see other side)

Patient Name _____ Date _____

Family Dentist _____ Physician _____

MEDICAL HISTORY

Yes	No	
☐	☐	Date of last physical examination _____
☐	☐	Are you currently under treatment for a physical or emotional problem?
☐	☐	Has there been any change in your general health or weight during the past year?
☐	☐	Are you taking any drugs or medication (including oral contraceptives or hyperkinetic drugs)?
☐	☐	Are you allergic to any drugs (including aspirin, penicillin or codeine)?
☐	☐	Have you been hospitalized for any operations or radiation treatment?
☐	☐	Have you ever had a serious accident involving head injuries?

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING:

YES	NO		YES	NO	
☐	☐	Blood disorder, anemia or bleeding problems?	☐	☐	Fainting spells, epilepsy or stroke?
☐	☐	Liver disease, hepatitis or jaundice?	☐	☐	Glaucoma, or other eye disorders?
☐	☐	Cardiovascular disease (heart attack, high/low blood pressure)?	☐	☐	Allergies, asthma, or hay fever?
☐	☐	Sinus trouble, tonsilitis, sore throat, or ear infection?	☐	☐	Thyroid or endocrine problems?
☐	☐	Ulcers, stomach, intestinal or bowel problems?	☐	☐	Congenital heart defects?
☐	☐	Rheumatic fever or rheumatic heart diseases?	☐	☐	Diabetes?
☐	☐	X-ray or chemo-therapy for a tumor?	☐	☐	Communicable disease?
☐	☐	Physical handicaps, mental retardation?	☐	☐	Are you pregnant?
☐	☐	Emotional problems, psychiatric care, alcoholism or drug addiction?	☐	☐	Kidney disease?
☐	☐	Respiratory disease, pneumonia, tuberculosis, shortness of breath	☐	☐	Have you reached puberty?

Please describe any other disease, condition, problems or current medical treatment, including impending operations, recent injuries or other information the doctor should be aware of:

_____

_____

_____

DENTAL HISTORY

Yes	No	
☐	☐	Date of last dental
☐	☐	Are you allergic to any local anesthetics (Novocain, Xylocain)?

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING:

☐	☐	Previous orthodontic consultation or treatment?
☐	☐	Periodontal surgery or treatment?
☐	☐	Treatment for a temporomandibular joint disorder?
☐	☐	Clicking or soreness when the mouth is opened?
☐	☐	Oral surgery or x-ray treatment of the jaws, mouth or lips?
☐	☐	Teeth extracted or missing?
☐	☐	Problems with bleeding or gum healing after surgery?
☐	☐	Injuries to face, mouth, or teeth?
☐	☐	Grinding / clenching teeth?
☐	☐	Sensitivity to heat,cold or sweets:
☐	☐	Fluoride treatments?
☐	☐	Speech therapy?
☐	☐	Other: _____

_____

_____

I certify that the above information is true and complete to the best of my knowledge.

_____

Signature

_____

Date