

Clinical Services Medical/Dental History

PLACE LABEL

Please complete this form as much as possible. All information is confidential
 This information is vital to allow us to provide appropriate care for you.

Name: _____ **Date of birth:** _____ **Height:** _____ **Weight:** _____

If you are completing this form for another person, what is your relationship to that person?
Your Name _____ **Relationship** _____

Do you have any of the following diseases or problems: Yes No DK *Check DK if you "Don't Know" the answer to the question.*

Active Tuberculosis

Persistent cough greater than a 3-week duration.....

Cough that produces blood

Been exposed to anyone with tuberculosis.....

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

<p>Do your gums bleed when you brush or floss?..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Are your teeth sensitive to cold, hot, sweets or pressure?..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Does food or floss catch between your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Is your mouth dry? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Have you had any periodontal (gum) treatments? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Have you ever had orthodontic (braces) treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Have you had any problems with previous dental treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Is your home water supply fluoridated? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Do you drink bottled or filtered water?..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>If yes, how often? Check one: <input type="checkbox"/> DAILY <input type="checkbox"/> WEEKLY <input type="checkbox"/> OCCASIONALLY</p> <p>Are you currently experiencing dental pain or discomfort? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p>	<p>Do you have earaches or neck pains? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Do you have any clicking, popping or discomfort in the jaw? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Do you brux or grind your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Do you have sores or ulcers in your mouth? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Do you participate in active recreational activities? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Have you ever had a serious injury to your head or mouth? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Date of your last dental exam: _____</p> <p>What was done at that time? _____</p> <p>_____</p> <p>Date of last dental x-rays: _____</p>
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What is the reason for your dental visit today? _____

How do you feel about your smile? _____

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

<p>Are you now under the care of a physician? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Physician Name: _____ Phone: _____</p> <p>Are you in good health? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Date of last physical exam? _____</p> <p>Has there been any change in your general health within the past year? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what condition is being treated? _____</p> <p>Do you wear contact lenses? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Do you use tobacco (smoking, snuff, chew, bidis)? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If so, how interested are you in stopping? (Circle one) VERY SOMEWHAT NOT INTERESTED</p> <p>Do you: (check box) <input type="checkbox"/> Drink alcohol <input type="checkbox"/> Take street drugs <input type="checkbox"/> Inject drugs <input type="checkbox"/> Share needles/equipment</p> <p>WOMEN ONLY Are you: Pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Number of weeks? _____</p> <p>Taking birth control pills or hormonal replacement? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Nursing/breastfeeding? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Are you experiencing domestic violence, sexual violence or human trafficking? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, would you like information or help today? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>Have you had a serious illness, operation or been hospitalized in the past 5 years? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what was the illness or problem? _____</p> <p>Are you taking, or have you recently taken any prescription or over the counter medicine(s)? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please list all medications, including vitamins, natural or herbal preparations and/or diet supplements? _____</p> <p>Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? Yes <input type="checkbox"/> No <input type="checkbox"/> Date: _____</p> <p>If yes, have you had any complications? _____</p> <p>Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Yes <input type="checkbox"/> No <input type="checkbox"/> Date Treatment began: _____</p>
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Allergies - Are you allergic to or have you had an allergic reaction to:											
Yes No DK			Yes No DK			Yes No DK					
Local Anesthetics:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Metals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever/seasonal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Latex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Iodine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Food:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives, or sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Codeine or other narcotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other _____

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

		Yes	No	DK			Yes	No	DK			Yes	No	DK			
Artificial (prosthetic) heart valve		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, jaundice or liver disease		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Previous infective endocarditis		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune disease		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells or seizures		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Damaged valves in transplanted heart		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disorders		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Congenital heart disease (CHD)					Systemic lupus erythematosus		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specify: _____							
Unrepaired, cyanotic CHD		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep disorder		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Repaired (completely) in last 6 months		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental health disorders		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Repaired CHD with residual defects		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Specify _____							
Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.					Sinus trouble		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____							
Angina	Yes No DK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Chest pain upon exertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular disease		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arteriosclerosis		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Congestive heart failure		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatment		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Persistent swollen glands in neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic pain		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe headaches/migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic heart disease		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Type I or II		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Damaged heart valves		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eating disorder		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS or HIV infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal bleeding		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Malnutrition		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Type of infection _____			
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal disease		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
				If yes, date: _____					G.E. Reflux/persistent, heartburn		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe or rapid weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Other congenital heart defects		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
									Hemophilia		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?..... Yes No

Name of physician or dentist making recommendation: _____ Phone: _____

NOTE: Both dental provider and patient are encouraged to discuss all relevant patient health issues prior to treatment.

Do you have any disease, condition, or problem not listed above that you think I should know about?..... Please explain:

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dental provider and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dental provider, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form

Signature of Patient/Legal Guardian: _____ Date: _____

FOR COMPLETION BY DENTAL PROVIDER

Comments _____