MEDICAL HISTORY

Name:_____ **Height**_____ **Weight**_____
Last **First** **MI** **Date**_____

PLEASE CIRCLE YOUR RESPONSES (*YES, NO, DK (DON'T KNOW)*) TO INDICATE IF YOU HAVE, HAVE NOT OR DO NOT KNOW IF YOU HAVE HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS.

Do you have any of the following diseases or problems? If you answer yes to any of the 4 items below, please stop. Talk to your student dentist or someone at the reception desk:

YES NO DK Active Tuberculosis
YES NO DK Persistent cough greater than 3 weeks in duration
YES NO DK Cough that produces blood
YES NO DK Been exposed to anyone with Tuberculosis

What is your impression of your health? **GOOD FAIR POOR**
Date of last physical examination (Month/Year): ____/_____

YES NO DK Are you now under the care of a physician? If yes, what is/are the condition(s) being treated?_____
_____

YES NO DK Has there been any change in your general health within the past year?
If yes, is the condition related to:
Heart/Rheumatic Fever (Specify): _____
Allergies (Specify): _____
Blood Pressure (Specify): _____
Diabetes (Specify): _____
Other (Specify): _____

YES NO DK Have you had any serious illness, operation, or been hospitalized in the past 5 years? If yes, what was the illness or problem? _____
YES NO DK Have you had an organ transplant? If yes, please specify: _____
YES NO DK Have you had an orthopedic total joint (e.g. hip, knee, elbow, finger) replacement?
If yes, what joint was replaced? _____
If yes, when was the joint replaced (Year)? _____
If yes, have you had any complications? **YES NO DK** If yes, please specify: _____
YES NO DK Have you ever had any radiation therapy or chemotherapy for a growth, tumor or other condition? If yes, please explain: _____
YES NO DK In the last 2 years, have you taken or are you now taking steroids (e.g. cortisone)? If yes, what steroid(s) and dose? _____ For how long? _____

Have you taken, are you taking or are you scheduled to begin taking?

YES NO DK -Oral bisphosphonates (Alendronate (Fosamax), Ibandronate (Boniva), or Risedronate (Actonel))?
If yes, what drug, dose and frequency?
Fosamax: Dose: _____ Frequency: _____
Boniva: Dose: _____ Frequency: _____
Actonel: Dose: _____ Frequency: _____
If yes, what for?
Osteoporosis
Paget's disease
Other (Specify): _____
If yes, when?
Past (Specify MONTH/YEAR started and how long taken): _____
Current (Specify MONTH/YEAR started): _____
Scheduled (Specify MONTH/YEAR treatment will begin): _____

YES NO DK -Intravenous bisphosphonates (Pamidronate (Aredia) or Zoledronic Acid (Zometa))?
If yes, what drug, dose and frequency?
Aredia: Dose: _____ Frequency: _____
Zometa: Dose: _____ Frequency: _____
If yes, what for?
Bone pain
Hypercalcemia
Skeletal complications from Paget's disease
Skeletal complications from multiple myeloma
Skeletal complications from metastatic cancer
If yes, when?
Past (Specify when started and how long taken): _____
Current (Specify when started): _____
Scheduled (Specify when treatment will begin): _____

YES NO DK Do you use tobacco (smoking, snuff, chew, bidis, vaping)?
If yes, please specify type: **SMOKING SNUFF CHEW BIDIS VAPES**
If yes, please specify amount per day: _____
If yes, how interested are you in stopping? **VERY SOMEWHAT NOT INTERESTED**

YES NO DK Do you drink alcoholic beverages?
If yes, how many drinks did you drink in the last 24 hours? _____
If yes, how many drinks do you typically drink in a week? _____
If yes, are you alcohol dependent? **YES NO DK**
If yes, how long have you been alcohol dependent (months)? _____
If yes, how many drinks do you drink per day? _____
If yes, have you received treatment? **YES NO**

YES NO DK Do you use drugs or other substances for recreational purposes?
If yes, please indicated drugs used:
COCAINE HEROIN OXYCONTIN METHAMPHETAMINE ECSTASY MARIJUANA OTHER(Specify)_____
If yes, how often do you use? _____
If yes, are you drug dependent? **YES NO DK**
If yes, how long have you been drug dependent (months)? _____
If yes have you received treatment? **YES NO**

WOMEN ONLY:

YES NO DK Are you pregnant? If yes, number of weeks: _____
YES NO DK Are you nursing?
YES NO DK Are you taking birth control pills, fertility drugs or hormonal replacement?

CHILDREN ONLY:

YES NO DK Are your child's immunizations up to date?
YES NO DK Does your child have Attention Deficit Hyperactivity Disorder?
YES NO DK Does your child have a learning disability?

YES NO DK Are you taking, have you recently (within the last month) taken, or are you supposed to be taking any medications (prescription, over the counter, diet supplements, vitamins, natural or herbal)? If yes, please specify medication(s), dosage and frequency:

Medication	Dosage/Frequency	Medication	Dosage/Frequency

ALLERGIES: Are you allergic to or have you had a reaction to any of the following?

For yes responses, please specify type of reaction:

YES NO DK Local anesthetics (Novocaine/epinephrine) **Reaction:** _____
YES NO DK Penicillin **Reaction:** _____
YES NO DK Other antibiotics (Specify): _____ **Reaction:** _____
YES NO DK Sulfa drugs **Reaction:** _____
YES NO DK Codeine or other narcotics **Reaction:** _____
YES NO DK Aspirin **Reaction:** _____
YES NO DK Barbiturates (sedatives or sleeping pills) **Reaction:** _____
YES NO DK Hay fever/seasonal (allergic rhinitis) **Reaction:** _____
YES NO DK Animals **Reaction:** _____
YES NO DK Metals/Jewelry (nickel/chrome) **Reaction:** _____
YES NO DK Food (Specify): _____ **Reaction:** _____
YES NO DK Iodine **Reaction:** _____
YES NO DK Latex (rubber) **Reaction:** _____
YES NO DK Other/Other Medication(s) (Specify): _____ **Reaction:** _____

MEDICAL CONDITIONS: Do you have or have you had any of the following diseases, problems, or symptoms?

YES NO DK *Cardiovascular/heart problem*
If yes, please specify:
- Rheumatic fever/Rheumatic heart disease
- Infective endocarditis
- Artificial heart valves
- Congenital heart defect
- Heart murmur
- Mitral valve prolapse
- Angina (chest pain)
- Heart attack
- Congestive heart failure
- Coronary heart disease
- High blood pressure
- Low blood pressure
- Arteriosclerosis
- Palpitations
- Arrhythmia (irregular heart beat)
- Shortness of breath
- Swelling of the ankles
- Pacemaker
- Implantable defibrillator
- Sleep on two or more pillows
- Other (Specify): _____

YES NO DK *Respiratory/lung problem*
If yes, please specify:
- Asthma
- Emphysema/COPD
- Tuberculosis
- Sarcoidosis
- Pneumonia
- Sinusitis
- Bronchitis
- Persistent cough
- Sleep apnea
- Snoring
- Other (Specify): _____

YES NO DK *Endocrine disorder*
If yes, please specify:
- Diabetes
  - Type 1
  - Type 2
  - Gestational
- Thyroid problems
  - Hypothyroidism
  - Hyperthyroidism
- Adrenal gland disorder
- Other (Specify): _____

YES NO DK *Kidney/urogenital disorder*
If yes, please specify:
- Kidney stones
- Renal failure/insufficiency
- Dialysis
- Prostate
- Frequent urination
- Other (Specify): _____

YES NO DK *Cancer or tumors*
If yes, please specify:
- Location: _____
- Malignant (Specify):_____
- Benign (Specify):_____

YES NO DK *Neurologic problem*
If yes, please specify:
- Stroke
- TIA (transient ischemic attack)
- Seizures/Epilepsy
- Multiple sclerosis
- Parkinson's disease
- Neuropathies
- Dementia/Alzheimer's (memory loss)
- Headache
- Fainting or dizzy spells
- Weakness
- Feeling of tingling or numbness
- Psychiatric disease/Mental health disorder
  - Bipolar/Manic depression
  - Schizophrenia
  - Depression
- Post traumatic stress disorder
- Obsessive/compulsive disorder
- ADD/ADHD (attention deficit disorder)
- Feelings of anxiety
- Feelings of depression
- Other (Specify): _____

YES NO DK *Blood/hematologic disorder*
If yes, please specify:
- Anemia
- Sickle cell disease
- Sickle cell trait
- Deep vein thrombosis
- Bruise easily
- Leukemia
  - Acute lymphocytic
  - Chronic lymphocytic
  - Acute myelogenous
  - Chronic myelogenous
- Lymphoma
  - Hodgkin's
  - Non-Hodgkin's
- Multiple myeloma
- Bleeding disorders
  - Hemophilia
  - Von Willebrand's
  - Drug induced
  - Idiopathic thrombocytopenic purpura
  - Thalassemia
  - Other (Specify): _____
- Other (Specify): _____

YES NO DK *Gastrointestinal (GI) disorder*
If yes, please specify:
- Cirrhosis/Chronic hepatitis
- Jaundice (skin/eyes turn yellow)
- Hepatitis
  - A
  - B
  - C
  - D
  - Other (Specify): _____
- Heartburn
- Gall stones
- Acid reflux (GERDS)
- Ulcers
- Crohn's disease
- Irritable bowel syndrome
- Other (Specify): _____

YES NO DK *Musculoskeletal/ connective tissue disorder*
If yes, please specify:
- Arthritis
  - Rheumatoid
  - Osteoarthritis
  - Other (specify): _____
- Osteoporosis
- Gout
- Temporomandibular joint disorder
- Lupus
- Scleroderma
- Other (Specify): _____

YES NO DK *Infectious disease*
If yes, please specify:
- HIV
- AIDS
- STD (sexually transmitted disease)
  - Syphilis
  - Gonorrhea
  - Chlamydia
  - Genital herpes
  - Human papillomavirus
- Cold sores
- Mononucleosis
- Other (Specify): _____

YES NO DK *Head/eye/ear/nose/throat problem*
If yes, please specify:
- Vision problems
- Wear contact lenses
- Glaucoma
- Cataract
- Hearing impairment
- Other (Specify): _____

YES NO DK *Dermatologic/skin problem*
If yes, please specify:
- Psoriasis
- Other (Specify): _____

YES NO DK *Eating disorder*
If yes, please specify:
- Bulimia
- Anorexia
- Other (Specify): _____

YES NO DK *Immunosurpression*

YES NO DK *Family history of diabetes*

YES NO DK *Family history of heart disease*

YES NO DK *Family history of cancer or tumors*

YES NO DK *Do you have any other problem, disease or condition not listed above?*
If yes, please specify:

_____

_____

_____

DENTAL HISTORY

What is the reason for your dental visit today? **EXAMINATION EMERGENCY CONSULTATION PROCEDURE**
How would you describe your current dental problem?_____
Date of your last dental visit (Month/Year): ____/_____
What was done at that time? **EXAMINATION EMERGENCY CONSULTATION PROCEDURE**
Date of your last dental exam (Month/Year): ____/_____ Date of your last dental x-rays (Month/Year): ____/_____
Date of your last dental cleaning (Month/Year): ____/_____

YES NO DK Are you currently experiencing dental pain or discomfort?
If yes, specify where? **UPPER RIGHT UPPER LEFT LOWER RIGHT LOWER LEFT**
YES NO DK Are your teeth sensitive to cold, hot, sweets or pressure? (Specify): **COLD HOT SWEETS PRESSURE**
If yes, specify where? **UPPER RIGHT UPPER LEFT LOWER RIGHT LOWER LEFT**
YES NO DK Do you have problems with eating (trouble chewing, vomiting, etc)? (Specify): **TROUBLE CHEWING VOMITING OTHER**
YES NO DK Do you have swelling in or around your mouth, face or neck? (Specify): **MOUTH FACE NECK**
YES NO DK Do you have loose teeth?
YES NO DK Do you have headaches, earaches or neck pains? (Specify): **HEADACHES EARACHES NECK PAINS**
YES NO DK Do you have any clicking, popping or discomfort in the jaw? (Specify): **CLICKING POPPING DISCOMFORT**
YES NO DK Do you clench, brux, or grind your teeth? (Specify): **CLENCH BRUX/GRIND BOTH**
YES NO DK Do you have sores or ulcers in your mouth?

YES NO DK Have you lost any teeth?
YES NO DK Do you have a history of tooth extraction or oral surgery (implants, cosmetic procedures or TMJ surgery)?
YES NO DK Have you had any periodontal (gum) treatments?
YES NO DK Do you have bridges or wear dentures or partials? (Specify): **BRIDGES DENTURES PARTIALS**
YES NO DK Have you ever had root canal treatment?
YES NO DK Have you ever had orthodontic (braces) treatment?
YES NO DK Have you had a local anesthetic (Novocaine) for dental purposes?
If yes, have you experienced any problems? **NO YES (Specify):** _____
YES NO DK Have you had any problems associated with previous dental treatment?
If yes, please specify: _____

How often do you brush your teeth?
NEVER SOMETIMES ONCE A DAY TWICE A DAY MORE THAN TWICE A DAY
How often do you floss your teeth?
NEVER SOMETIMES ONCE A WEEK ONCE A DAY MORE THAN ONCE A DAY
YES NO DK Do your gums bleed when you brush or floss?
YES NO DK Do you have any obstacles to cleaning or caring for your teeth?
YES NO DK Does food or floss catch between your teeth?
YES NO DK Is your mouth dry?
YES NO DK Is your home water supply fluoridated?
YES NO DK Do you drink bottled or filtered water? If yes, how often: **DAILY WEEKLY OCCASIONALLY**
YES NO DK Do you have a diet high in sugar?
If yes, which of the following do you consume more than once per day?
Candy/Mints/Gum
Coffee/Tea with sugar
Soda pop
Sports drinks
Cough drops
Other foods high in sugar

YES NO DK Do you participate in active recreational activities or sports?
YES NO DK Have you ever had a serious injury to your head or mouth?
YES NO DK Are you unhappy with your smile or the appearance of your teeth?
YES NO DK Are you worried about losing your teeth?

Rate your fear of dental treatment on a scale of 0 (no fear) - 10 (extreme fear): _____
Please state any questions or concerns about dentistry or your dental health: _____

CHILDREN ONLY:
YES NO DK Is this the child's 1st visit to the dentist?
YES NO DK Does the child suck the thumb/finger/pacifier?
YES NO DK Is the child extremely nervous about dentistry?
YES NO DK Has the child had any difficult visits to the physician or hospital?

What are the typical between meal snacks for the child?_____

Did an interpreter help you with these forms? **YES NO**
If you are completing these forms for the patient what is your relationship to the patient? **MOTHER FATHER GUARDIAN OTHER**

Your name: _____