

Medical and Dental Questionnaire

Dental Record Number _____
Patient Name (Last, First, MI) _____
Date of Birth (MM/DD/YYYY) _____

Mark your response to indicate if you have had any of the following diseases or problems.
 Mark **don't know (DK)** if you are unsure whether you have had the disease or problem.
 If you have a disease or problem that is not listed below, write the disease or condition in the space at the bottom of this form.

Yes No DK **Physician:** Name _____ Telephone _____
 Do you have tuberculosis?
 Are you pregnant? Address: _____

Date of last physical examination: _____ Yes No DK Any changes in your health within the past year? Yes No DK Cardiovascular High blood pressure Angina (chest pain) Heart attack Irregular heart beat Heart surgery Heart failure Damaged heart valve High cholesterol Heart infection Stroke Yes No DK Hematologic Anemia Sickle cell anemia Abnormal bleeding Yes No DK Respiratory Asthma Emphysema/bronchitis Sleep apnea Difficulty breathing Yes No DK Endocrine Diabetes Thyroid problem Yes No DK Renal Kidney disorder Dialysis	Yes No DK Immune Past use of steroids Delayed healing Yes No DK Musculoskeletal Arthritis Artificial joint Fibromyalgia Lupus Sjogren's Syndrome Osteoporosis Yes No DK Gastrointestinal Acid reflux/GERD Irritable bowel syndrome Stomach ulcer Yes No DK Hepatic Liver disease Jaundice Hepatitis Yes No DK Neurologic Epilepsy/seizures Parkinson's Disease Multiple sclerosis Headaches Yes No DK Skin Hives or skin rash Other skin lesions Yes No DK Eyes/Ears Glaucoma Impaired vision Impaired hearing	Yes No DK Mental Health Bipolar disorder Depression Anxiety Eating disorders Sleep disorder Dementia Learning disorders Yes No DK Infections HIV positive/AIDS Sexually transmitted disease Yes No DK Allergies Local anesthetic Antibiotics Aspirin/ibuprofen Acetaminophen (Tylenol) Codeine/narcotics Metals Latex Other: _____ Yes No DK Other Cancer Cancer treatment Nursing infant Tobacco use Alcohol use Chemical dependency Street/recreational/illicit drug use
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Please list any disease, condition, or problem you have that is not listed above.

Please list any hospitalizations or surgeries you have had.

Dental Information

<p>Yes No</p> <p>Is it important for you to keep your teeth? Are you satisfied with the appearance of your teeth? Are you satisfied with the function of your teeth? Does food frequently get caught between teeth? Do your gums often bleed while brushing? Have you noticed loosening of your teeth? Have you injured your head, neck, or jaw? Do you have difficulty eating or swallowing? Do you have a dry mouth? Have you had a change in your ability to taste foods?</p> <p>Yes No Problems of the jaw – Have you noticed: Clicking of the jaw? Pain (joint, ear, side of face)? Difficulty opening or closing? Difficulty chewing?</p> <p>Yes No Oral habits: Do you: Clench or grind your teeth? Bite your lips or cheek frequently?</p>	<p>Yes No Have you had: Orthodontic treatment (braces)? Oral surgery? Gum treatment? Your bite adjusted? A bite plane/guard or other appliance?</p> <p>Yes No Do you currently have: Dental pain? Sores or swellings in your mouth? A partial/full denture or dental implants? Do you supplement your diet with fluoride? Have you had any difficulty with dental treatment?</p> <p>Date of last dental x-rays _____ How often do you brush your teeth? _____ How often do you floss? _____ Date of last dental treatment: _____ Date of last teeth cleaning: _____</p> <p>Reason for today's dental visit? _____</p>
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Please explain if you answered “Yes” to, or are uncertain about, any of the above items.

To the best of my knowledge, the preceding information is complete and correct.

_____ **Signature – Patient (or parent/guardian if patient is under 18)** _____ **Date**

MEDICAL UPDATES

I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	PATIENT SIGNATURE	CHANGES TO HEALTH HISTORY	STUDENT INITIALS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____