

Name _____

Date of Birth _____

Occupation _____

Please answer the following 3 questions by filling in the blanks. If you need help, ask the receptionist or your dental student.

- | | |
|---|---|
| <p>1. Chief complaint:
What is or are your reasons for being here?</p> <p>History of chief complaint:</p> | <p>1. _____

_____</p> |
| <p>2. Is there anything or anyone preventing you
From seeking appropriate medical/dental care?</p> | <p>2. _____
_____</p> |
| <p>3. Last dental visit and reason for visit:</p> | <p>3. _____

_____</p> |

4. Past dental history (check all previous dental services received):
- | | |
|--|--|
| <input type="checkbox"/> Dental exam with x-rays | <input type="checkbox"/> Complete dentures (plates) |
| <input type="checkbox"/> Tooth extraction or oral surgery | <input type="checkbox"/> Periodontal treatment (gum treatment) |
| <input type="checkbox"/> Restorations (fillings) | <input type="checkbox"/> Endodontic treatment (root canal treatment) |
| <input type="checkbox"/> Partial dentures (removable) | <input type="checkbox"/> Orthodontic treatment (braces) |
| <input type="checkbox"/> Crown and bridgework (fixed) | |
| <input type="checkbox"/> Special diagnostic exam – Explain _____ | |

5. Previous dental experiences
- Unpleasant experience with dentist(s) in past (describe) _____
- Pleased with previous dental experience

6. Self analysis of oral health (check any problems that you have)
- | | |
|--|---|
| <input type="checkbox"/> Bad teeth (cavities) | <input type="checkbox"/> Bleeding gums |
| <input type="checkbox"/> Crooked teeth | <input type="checkbox"/> Swelling in mouth or jaws on occasion (<u>underline which</u>) |
| <input type="checkbox"/> "Dry Mouth" (not enough saliva) | <input type="checkbox"/> Loose or drifting teeth |
| <input type="checkbox"/> Bad bite: bite feels off | <input type="checkbox"/> Food catching between teeth |
| <input type="checkbox"/> Frequent sores in mouth or on lips | <input type="checkbox"/> Bad taste in mouth |
| <input type="checkbox"/> Teeth painful to hot, cold, sweets (<u>underline which</u>) | <input type="checkbox"/> Severe toothaches |
| <input type="checkbox"/> Other problems (describe) _____ | |

7. Attitudes about dentistry
- | | | |
|--------------------------|--------------------------|---|
| Y | N | |
| <input type="checkbox"/> | <input type="checkbox"/> | Most people will eventually lose their teeth. |
| <input type="checkbox"/> | <input type="checkbox"/> | Good dental care can prevent tooth loss. |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you only see the dentist for emergency care? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you brush every day? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you floss every day? |

8. Oral Habits
- | | |
|--|---|
| <input type="checkbox"/> <input type="checkbox"/> Do you or have you ever smoked cigarettes? | Frequency: _____ packs per day _____ years |
| <input type="checkbox"/> <input type="checkbox"/> Do you chew tobacco or use snuff? | Frequency: _____ times per day _____ years |
| <input type="checkbox"/> <input type="checkbox"/> Do you drink alcohol? | Frequency: _____ times per day |
| <input type="checkbox"/> <input type="checkbox"/> Do you chew gum? | Frequency: _____ sticks per day |
| <input type="checkbox"/> <input type="checkbox"/> Do you drink sugary drinks frequently? | Frequency: _____ number of 12 oz cans per day |

HEALTH HISTORY

Review of Systems

Please do not write in spaces below

CARDIOVASCULAR	Yes	No		
	1.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been told you have heart trouble?
	2.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been told you have <input type="checkbox"/> high or <input type="checkbox"/> low blood pressure
	3.	<input type="checkbox"/>	<input type="checkbox"/>	Do you get out of breath easily?
	4.	<input type="checkbox"/>	<input type="checkbox"/>	Have you had rheumatic fever?
	5.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a heart murmur as a consequence of rheumatic fever?
	6.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a prolapsed mitral valve?
	7.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been told that you have a heart murmur of any cause?
	8.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been told to take antibiotics before dental treatment?
	9.	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a heart attack?
	10.	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a stroke?
	11.	<input type="checkbox"/>	<input type="checkbox"/>	Do your ankles become easily swollen?
	12.	<input type="checkbox"/>	<input type="checkbox"/>	Do you suffer from angina pectoris (chest and left arm pain)?
13.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever taken the weight reduction drug Fen-phen?	

SENSES	1.	<input type="checkbox"/>	<input type="checkbox"/>	Have you had earaches or other ear problems?
	2.	<input type="checkbox"/>	<input type="checkbox"/>	Have you had eye problems such as glaucoma or other problems?
	3.	<input type="checkbox"/>	<input type="checkbox"/>	Have you noticed any changes in your sense of taste or smell?
	4.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have bad breath (halitosis)?
	5.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have headaches?
	6.	<input type="checkbox"/>	<input type="checkbox"/>	Do you feel tired or have significant body discomfort?
	7.	How well do you sleep? <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor		
	8.	<input type="checkbox"/>	<input type="checkbox"/>	Do you wake up feeling tired?
	9.	Do you snooze during the day? <input type="checkbox"/> None <input type="checkbox"/> A Little <input type="checkbox"/> Some <input type="checkbox"/> A Lot		

RESPIRATORY	1.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have the flu or a cold more than twice a year?
	2.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have asthma, hayfever, sinusitis, or frequent sore throats?
	3.	<input type="checkbox"/>	<input type="checkbox"/>	Have you had pneumonia or a lung infection?
	4.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have, or have you been exposed to, tuberculosis?
	5.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a chronic cough or cough up blood?
	6.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have bronchitis or emphysema?

NEUROLOGIC	1.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been under psychiatric care or had counseling?
	2.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have numbness or tingling feelings anywhere?
	3.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a nervous breakdown?
	4.	<input type="checkbox"/>	<input type="checkbox"/>	Are you anxious or depressed frequently?
	5.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have epilepsy, seizures, or other neurologic disorders?

ENDOCRINE	1.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have diabetes?
	2.	<input type="checkbox"/>	<input type="checkbox"/>	Does any member of your family have diabetes?
	3.	<input type="checkbox"/>	<input type="checkbox"/>	Are you thirsty frequently or urinate frequently?
	4.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have thyroid problems or take thyroid tablets?
	5.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any other gland problems?

G-I	1.	<input type="checkbox"/>	<input type="checkbox"/>	Have you had jaundice, liver trouble or hepatitis?
	2.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have stomach problems or ulcers?
	3.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have frequent or prolonged diarrhea or constipation?
	4.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have frequent episodes of acid reflux or vomiting?
	5.	<input type="checkbox"/>	<input type="checkbox"/>	Has your weight changed more than 20 pounds in the past year?

G-U	1.	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been told that you have kidney or bladder trouble?
	2.	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any sexually transmitted disease (syphilis, gonorrhea, genital herpes, HIV infection, AIDS)?
	3.	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any reproductive tract problems?

HEMATOLOGY	1.	<input type="checkbox"/>	<input type="checkbox"/>	Have you had anemia?
	2.	<input type="checkbox"/>	<input type="checkbox"/>	Do you have leukemia?
	3.	<input type="checkbox"/>	<input type="checkbox"/>	Do you bruise or bleed easily?

IMMUNOLOGY	Yes No		
	1. <input type="checkbox"/> <input type="checkbox"/>	Are you sensitive or allergic to any medications? (penicillin, sulfa drugs, aspirin, etc)	
	3. <input type="checkbox"/> <input type="checkbox"/>	Are you allergic to any foods, metals, pollens or latex (rubber)?	
	4. <input type="checkbox"/> <input type="checkbox"/>	Have you been treated for a skin disease?	
	5. <input type="checkbox"/> <input type="checkbox"/>	Do you have a defective immune system?	
	6. <input type="checkbox"/> <input type="checkbox"/>	Do you take medications that suppress your immune system?	

MUSCSEL	1. <input type="checkbox"/> <input type="checkbox"/>	Are your joints often painfully swollen or do you have arthritis?	
	2. <input type="checkbox"/> <input type="checkbox"/>	Do you have back problems?	
	3. <input type="checkbox"/> <input type="checkbox"/>	Have you had more than one fracture or dislocation?	
	4. <input type="checkbox"/> <input type="checkbox"/>	Do you have osteoporosis?	
	5. <input type="checkbox"/> <input type="checkbox"/>	Have you ever taken drugs for osteoporosis/osteopenia or as part of therapy for cancer or cancer prevention?	
	If you answered "yes" to question #5. above, please answer questions #6 - #11.		
	If you answered "no" to #5, skip to the next section.		
	6. _____	Name and dosage of medication for bones	
	7. _____	When did you start taking it?	
	8. _____	Are you still taking it?	
9. _____	When did you stop taking it?		
10. _____	Did you take it by "mouth" or by "injection or shot" (circle)		

SURGERY-ANESTHESIA	1. <input type="checkbox"/> <input type="checkbox"/>	Have you had an operation?	
	2. <input type="checkbox"/> <input type="checkbox"/>	Have you had a series of shots or injections?	
	3. <input type="checkbox"/> <input type="checkbox"/>	Have you ever had anesthesia? <input type="checkbox"/> Local <input type="checkbox"/> General	
	4. <input type="checkbox"/> <input type="checkbox"/>	Have you ever been told not to take novocaine or any other medication?	
	5. <input type="checkbox"/> <input type="checkbox"/>	Have you ever been told you had cancer or a tumor?	
	6. <input type="checkbox"/> <input type="checkbox"/>	Have you ever had chemotherapy?	
	7. <input type="checkbox"/> <input type="checkbox"/>	Have you ever had radiation therapy?	
	8. <input type="checkbox"/> <input type="checkbox"/>	Have you ever had an organ or bone marrow transplant?	
	9. <input type="checkbox"/> <input type="checkbox"/>	Are you using any recreational drugs or substances?	
	10. <input type="checkbox"/> <input type="checkbox"/>	Are you an active or recovering substance abuse?	

IMPLANTS	1. <input type="checkbox"/> <input type="checkbox"/>	Do you have a prosthetic (artificial) heart valve?	
	2. <input type="checkbox"/> <input type="checkbox"/>	Do you have a pacemaker or defibrillator?	
	3. <input type="checkbox"/> <input type="checkbox"/>	Have you had vascular or cardiac repair with synthetic materials?	
	4. <input type="checkbox"/> <input type="checkbox"/>	Do you have a vascular shunt (hemodialysis or drug therapy)?	
	5. <input type="checkbox"/> <input type="checkbox"/>	Do you have any prosthetic joints (hip, knee, ankle, shoulder)?	
	6. <input type="checkbox"/> <input type="checkbox"/>	Do you have any other implant?	

FACIAL PAIN	1. <input type="checkbox"/> <input type="checkbox"/>	Do you have a history of head or neck injury?	
	2. <input type="checkbox"/> <input type="checkbox"/>	Have you ever had severe pains of the face or head?	
	3. <input type="checkbox"/> <input type="checkbox"/>	Do you suffer from headache, eye pain or migraine?	
	4. <input type="checkbox"/> <input type="checkbox"/>	Do you have ear pain or pain in front of our ears?	
	5. <input type="checkbox"/> <input type="checkbox"/>	Does anything hurt when you chew?	
	6. <input type="checkbox"/> <input type="checkbox"/>	Does your jaw make noise that bothers you or others?	
	7. <input type="checkbox"/> <input type="checkbox"/>	Does the pain or discomfort interfere with your work activities?	

WOMEN	For Women Only:		
	1. <input type="checkbox"/> <input type="checkbox"/>	Are you taking birth control pills or have Norplant?	
	2. <input type="checkbox"/> <input type="checkbox"/>	Are you pregnant? Expected delivery date: _____	
	3. <input type="checkbox"/> <input type="checkbox"/>	Are you breast feeding?	

I verify that, to the best of my knowledge, the above health history is correct: _____
Patient Signature

Overall health _____
When was the patient's last physical exam by a Physician? _____
Physician's Name(s): _____
Address(es) _____
Phone(s) () _____

HOSPITALIZATIONS OR OUTPATIENT PROCEDURES	Year	City	Procedure	Complications

INITIAL SUMMARY	BLOOR PRESSURE:		PULSE:		
	Student/Number	Medical Consult Requested Yes No	Faculty/Number	Consult Received (Faculty Name/#)	Date
	Reason:				

PATIENT'S NAME: _____

CHART # _____

DATE	DRUG NAME	DRUG CLASSIFICATION	PRESCRIBED FOR	CONTRAINDICATIONS OR INTERACTIONS
1. <input type="checkbox"/> CURRENT <input type="checkbox"/> DISCONT'D	BRAND:			
	GENERIC:			
2. <input type="checkbox"/> CURRENT <input type="checkbox"/> DISCONT'D	BRAND:			
	GENERIC:			
3. <input type="checkbox"/> CURRENT <input type="checkbox"/> DISCONT'D	BRAND:			
	GENERIC:			
4. <input type="checkbox"/> CURRENT <input type="checkbox"/> DISCONT'D	BRAND:			
	GENERIC:			
5. <input type="checkbox"/> CURRENT <input type="checkbox"/> DISCONT'D	BRAND:			
	GENERIC:			
6. <input type="checkbox"/> CURRENT <input type="checkbox"/> DISCONT'D	BRAND:			
	GENERIC:			

PATIENT'S NAME: _____

CHART # _____

DATE	DRUG NAME	DRUG CLASSIFICATION	PRESCRIBED FOR	CONTRAINDICATIONS OR INTERACTIONS
7. <input type="checkbox"/> CURRENT <input type="checkbox"/> DISCONT'D	BRAND:			
	GENERIC:			
8. <input type="checkbox"/> CURRENT <input type="checkbox"/> DISCONT'D	BRAND:			
	GENERIC:			
9. <input type="checkbox"/> CURRENT <input type="checkbox"/> DISCONT'D	BRAND:			
	GENERIC:			
10. <input type="checkbox"/> CURRENT <input type="checkbox"/> DISCONT'D	BRAND:			
	GENERIC:			
11. <input type="checkbox"/> CURRENT <input type="checkbox"/> DISCONT'D	BRAND:			
	GENERIC:			
12. <input type="checkbox"/> CURRENT <input type="checkbox"/> DISCONT'D	BRAND:			
	GENERIC:			