

DENTAL PATIENT MEDICAL HISTORY

Please complete the **Patient Identification** section in order to update our records.

Name: _____ Date of Birth: _____ Home Phone: (____) _____

Cell Phone: (____) _____ Mail Address: _____ City: _____ State: _____ Zip: _____

If you are unsure how to answer any of the following questions, please ask the dental staff for help.

What is the reason for your visit to the dental clinic? _____

What is the name of your medical doctor? _____ **Last Physical Exam** _____

Has there been any change in your general health this past year? Yes ___ No ___

If you answered yes please explain _____

Do you require a **PREMED** or antibiotic before dental treatment (artificial joint or heart condition) Yes ___ No ___

If yes, why _____

List any medication (pills or drugs) you are currently taking: _____

Are you **ALLERGIC** to or made sick by any medications? _____

What is your sexual orientation? ___ Heterosexual ___ Homosexual ___ Something Else
___ Bisexual ___ Do not wish to say

What is your gender? ___ Male ___ Female ___ Other ___ Refused to Report
___ Transgender Male/Female-to-Male ___ Transgender Female/ Male-to-Female

Yes ___ No ___ 1. Do you use alcohol or other drugs?

Yes ___ No ___ 2. Do you have a toothache now?

Yes ___ No ___ 3. Have you taken medication in the last two months?

Yes ___ No ___ 4. Do you take Bisphosphonates?

Yes ___ No ___ 5. Have you ever been hospitalized?

Yes ___ No ___ 6. Do you have chest pains?

Yes ___ No ___ 7. Have you received medical care in the past two years?

Yes ___ No ___ 8. Have you ever had a bleeding problem that needed medical treatment?

Yes ___ No ___ 9. Do you have AIDS or HIV?

Yes ___ No ___ 10. Do you have Diabetes?

Yes ___ No ___ 11. Does anyone in your family have Diabetes? Who? _____

Yes ___ No ___ 12. Are you currently receiving care for your Diabetes?

Yes ___ No ___ 13. Do you receive care for your Diabetes at CHCBH?

14. Tobacco Use (select all that apply):

- ___ Smoker ___ Nonsmoker
 Vape Chew
 Cigarettes

Do you have or have you ever had any of the following:

Yes ___ No ___ 15. TB or Lung Disease

Yes ___ No ___ 16. Hepatitis

Yes ___ No ___ 17. Heart Murmur

Yes ___ No ___ 18. Heart Attack

Yes ___ No ___ 19. High Blood Pressure

Yes ___ No ___ 20. Rheumatic Fever

Yes ___ No ___ 21. Kidney Problems

Yes ___ No ___ 22. Heart valve or Pacemaker?

Yes ___ No ___ 23. Artificial Joint

Yes ___ No ___ 24. Anemia

Yes ___ No ___ 25. Stroke

Yes ___ No ___ 26. Ulcers

Yes ___ No ___ 27. Asthma

Yes ___ No ___ 28. Sinus Trouble

Yes ___ No ___ 29. Cancer or Tumors

Yes ___ No ___ 30. Epilepsy or seizure

Yes ___ No ___ 31. Arthritis/Rheumatism

Yes ___ No ___ 32. Blood Transfusion

Yes ___ No ___ 33. Sexually transmitted diseases

Yes ___ No ___ 34. Liver Problems

Yes ___ No ___ 35. Mental Disorders

Yes ___ No ___ 36. Depression

Yes ___ No ___ 37. Osteoporosis

Yes ___ No ___ 38. Acid Reflux

Females Only:

Yes ___ No ___ 39. Are you pregnant?

Yes ___ No ___ 40. Taking birth control pills?

Yes ___ No ___ 41. Currently Nursing?

Do you have any conditions/problems, not listed above, which may be a factor in your treatment? Yes ___ No ___

Who is your present dentist? _____

Do you have concerns about receiving dental treatment? Yes ___ No ___ If yes specify _____

The answers I have given are true to the best of my knowledge. I am indicating my consent for routine dental procedures such as x-rays, cleanings, fillings, crowns, and local anesthesia by signing below.

Patient or Legal Guardian Signature: _____ Date: _____

Notes (For dental staff use): _____

Dentist Signature: _____ Date: _____

Provider Review: Date _____ Ini. _____ Date _____ Ini. _____ Date _____ Ini. _____ Date _____ Ini. _____