

MEDICAL DENTAL HISTORY FORM

Patient Name: _____

Senior Community: _____

Patient ID #: _____

Physician _____

Allergies to:

PreMed required? Yes No

Latex: Yes No

Reason: _____

Medications _____

Other _____

Type: _____ Dosage: _____

Current Medications (Prescription, Over the counter and Herbal)

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY

PAST AND CURRENT MEDICAL CONDITIONS (mark all that apply)

	Yes		Yes
8 Under physician's care?	<input type="checkbox"/>	34 Asthma?	<input type="checkbox"/>
Details:		35 Sleep Apnea?	<input type="checkbox"/>
9 Hospitalization/operation(s) in last 5 years?	<input type="checkbox"/>	36 Tuberculosis?	<input type="checkbox"/>
Details:		37 Sinus trouble?	<input type="checkbox"/>
10 Head/neck/mouth injuries?	<input type="checkbox"/>	38 Cancer?	<input type="checkbox"/>
11 Women: pregnant?	<input type="checkbox"/>	39 Radiation Treatment to Head/Neck?	<input type="checkbox"/>
12 Women: nursing?	<input type="checkbox"/>	40 Chemotherapy?	<input type="checkbox"/>
13 Women: oral contraceptives?	<input type="checkbox"/>	41 Kidney Disease?	<input type="checkbox"/>
14 Heart trouble/disease?	<input type="checkbox"/>	42 Dialysis?	<input type="checkbox"/>
15 Rheumatic fever?	<input type="checkbox"/>	43 Eating Disorder?	<input type="checkbox"/>
16 Past use of Fenphen?	<input type="checkbox"/>	44 Stomach: reflux? ulcer?	<input type="checkbox"/>
17 Heart murmur?	<input type="checkbox"/>	45 Immunological disease?	<input type="checkbox"/>
18 Mitral valve prolapse?	<input type="checkbox"/>	46 Sjogrens Disease?	<input type="checkbox"/>
19 Heart surgery?	<input type="checkbox"/>	47 Fibromyalgia?	<input type="checkbox"/>
20 Artificial heart valves?	<input type="checkbox"/>	48 Other autoimmune disease (lupus, pemphilus)?	<input type="checkbox"/>
21 Pacemaker?	<input type="checkbox"/>	49 Arthritis or other joint disorders?	<input type="checkbox"/>
22 Indwelling defibrillator?	<input type="checkbox"/>	50 Diabetes? Type: _____ Controlled? Y N	<input type="checkbox"/>
23 Artificial joints?	<input type="checkbox"/>	51 Headaches?	<input type="checkbox"/>
24 History of Organ Transplant?	<input type="checkbox"/>	52 Depression: Diagnosed?	<input type="checkbox"/>
25 High blood pressure? BP: /	<input type="checkbox"/>	53 Other Psychiatric Disorders?	<input type="checkbox"/>
26 Stroke?	<input type="checkbox"/>	54 Neurologic Disease?	<input type="checkbox"/>
27 Bleeding problem?	<input type="checkbox"/>	55 Convulsions?	<input type="checkbox"/>
28 Hemophilia?	<input type="checkbox"/>	56 Epilepsy/seizures?	<input type="checkbox"/>
29 Anemia?	<input type="checkbox"/>	57 Cerebral Palsy?	<input type="checkbox"/>
30 Leukemia?	<input type="checkbox"/>	58 Fainting/dizziness?	<input type="checkbox"/>
31 Lung disease?	<input type="checkbox"/>	59 Venereal disease?	<input type="checkbox"/>
32 Emphysema?	<input type="checkbox"/>	60 AIDS/HIV positive?	<input type="checkbox"/>
33 Shortness of Breath?	<input type="checkbox"/>	61 Alcohol or chemical dependency?	<input type="checkbox"/>
		62 Hepatitis?	<input type="checkbox"/>
		63 Thyroid disease?	<input type="checkbox"/>
		64 Glaucoma?	<input type="checkbox"/>

TOBACCO

PAST DENTAL TREATMENT:

65 Tobacco user?	Yes	<input type="checkbox"/>
Type:		
Amount:		
Number of years:		
66 How soon after wake up do you use tobacco? <div style="text-align: center;"><30 minutes >30 minutes</div>		
67 Previous attempts to quit?		<input type="checkbox"/>
Number of attempts:		
Longer period of success:		
Methods used:		
68 Are you interested in quitting tobacco?		<input type="checkbox"/>
69 Former tobacco user?		<input type="checkbox"/>
Type:		
Amount:		
Year quit:		

82 One or more fillings in the last three years?	Yes	<input type="checkbox"/>
83 Family history of extensive decay?		<input type="checkbox"/>
84 If Child, mother's history of decay?		<input type="checkbox"/>
85 Treatment for periodontal (gum) disease?		<input type="checkbox"/>
86 Family history of periodontal disease?		<input type="checkbox"/>
87 Have you had orthodontics (braces)?		<input type="checkbox"/>
88 Have you had oral surgery?		<input type="checkbox"/>
89 Have you had any dental implants placed?		<input type="checkbox"/>
90 Treatment for temporomandibular disorders?		<input type="checkbox"/>
91 Do you wear a denture(s) or partial denture(s)?		<input type="checkbox"/>

DENTAL INFORMATION:

70 Previous dentist:		
71 Last dental visit:		
72 Last dental cleaning:		
73 Frequency of dental exams:		
74 What made you decide to make this dentist appointment?		
75 Frequency of brushing:		
76 Frequency of flossing:		
77 What are some typical foods you eat between meals?		
78 What types of beverages do you typically drink between meals?		
79 How often do you chew or suck on hard candy, cough drops or mints?		
80 Do you use fluoridated toothpaste?	Yes	<input type="checkbox"/>
81 Primary source of drinking water? (circle)		
City water filtered City water unfiltered		
Bottled water Well water		

DO YOU HAVE CONSISTENT PROBLEMS WITH:

92 Dry mouth/excessive thirst?	<input type="checkbox"/>
93 Sensitive teeth? Hot Cold Pressure Sweets	<input type="checkbox"/>
94 Mouth odors/bad taste?	<input type="checkbox"/>
95 Cold sores/blisters/oral lesions?	<input type="checkbox"/>
96 Are you aware of any swelling or lumps?	<input type="checkbox"/>
97 Sore, bleeding gums?	<input type="checkbox"/>
98 Loose teeth?	<input type="checkbox"/>
99 Difficulty chewing?	<input type="checkbox"/>
100 Food catches between teeth?	<input type="checkbox"/>
101 Teeth/filling break frequently?	<input type="checkbox"/>
102 Clenching or grinding habits?	<input type="checkbox"/>
103 Do you hear popping, clicking or snapping?	<input type="checkbox"/>
104 Do you have jaw pain?	<input type="checkbox"/>
105 Are you nervous about dental work?	<input type="checkbox"/>

Patient/Guardian/POA Signature: _____ Date: _____