Idaho State University

ISU Family Dentistry
1311 E. Central Dr., Meridian, ID 83642
Phone: 208.373.1855 / Fax: 208.373.1856

PATIENT NAME:_____ DATE OF BIRTH:_____

Please **CIRCLE** the appropriate response next to each question below: Yes (Y), No (N), Don't Know (?)

Medical History

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

1. Breathing Problems?

a.	Asthma	Y	N	?
b.	Emphysema	Y	N	?
c.	Bronchitis	Y	N	?
d.	Tuberculosis	Y	N	?
e.	Shortness of breath	Y	N	?
f.	Sleep Apnea or use a CPAP	Y	N	?
g.	Other breathing problems	Y	N	?

Explain_____

2. Heart or circulation problems?

a.	High blood pressure	Y	N	?
b.	Heart Attack	Y	N	?
c.	Angina or chest pain	Y	N	?
d.	Irregular heart beat	Y	N	?
e.	Rheumatic Fever	Y	N	?
f.	Heart murmur	Y	N	?
g.	Mitral Valve Prolapse	Y	N	?
h.	Damage to heart valves	Y	N	?
i.	Heart valve replacement	Y	N	?
j.	Pacemaker	Y	N	?
k.	Cardiac Stent/other device	Y	N	?
l.	Congestive heart failure	Y	N	?
m.	Swollen ankles	Y	N	?
n.	Other heart or circulation problems	Y	N	?

Explain _____

3. Muscle, bone or skin problems?

a.	Arthritis	Y	N	?
b.	Osteoporosis, Osteopenia bone loss	Y	N	?
c.	Artificial joint placement	Y	N	?
d.	Hives or skin rash	Y	N	?
e.	Skin cancer	Y	N	?
f.	Back problems	Y	N	?
g.	Other muscle, bone or skin disease	Y	N	?

Explain_____

4. Kidney or urinary problems?

a.	Kidney Disease	Y	N	?
b.	Dialysis	Y	N	?
c.	Frequent urination	Y	N	?
d.	Other kidney problems	Y	N	?

Explain_____

5. Nervous System problems?

a.	Stroke/Transient ischemic attack (TIA)	Y	N	?
b.	Fainting Spells	Y	N	?
c.	Convulsions, seizure or epilepsy	Y	N	?
d.	Other nervous system problems	Y	N	?

Explain _____

6. Head and neck problems?

a.	Nose or sinus problems	Y	N	?
b.	Swollen glands	Y	N	?
c.	Oral Cancer	Y	N	?
d.	Impairment of hearing, sight or speech	Y	N	?
e.	Frequent or severe headaches	Y	N	?
f.	Other head and neck problems	Y	N	?

Explain_____

7. Hormone or gland problems?

a.	Thyroid disease	Y	N	?
	Type:_____			
b.	Diabetes	Y	N	?
	Type I or Type II:_____			
	HbA1c:_____			
c.	Adrenal or pancreatic disease	Y	N	?
d.	Addison's disease	Y	N	?
e.	Steroid use	Y	N	?
f.	Any other hormone/gland disease	Y	N	?

Explain_____

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8. Stomach, liver or intestinal problems?

a.	Liver disease	Y	N	?
b.	Hepatitis	Y	N	?
c.	Acid Reflux (GERD)	Y	N	?
d.	Ulcers	Y	N	?
e.	Other stomach or intestinal problems	Y	N	?
f.	Other liver problems	Y	N	?

Explain_____

9. Allergic reactions or other problems?

a.	Seasonal allergies	Y	N	?
b.	Allergy, reaction or intolerance			
	Penicillin	Y	N	?
	Erythromycin	Y	N	?
	Codeine	Y	N	?
	Latex	Y	N	?
	Local anesthetic	Y	N	?
	Foods/flavoring	Y	N	?
	Other substances	Y	N	?

Explain _____

10. Blood or immune system problems?

a.	Cancer of any type	Y	N	?
b.	Organ or bone marrow transplant	Y	N	?
c.	Lupus	Y	N	?
d.	Multiple sclerosis	Y	N	?
e.	Anemia	Y	N	?
f.	Hemophilia	Y	N	?
g.	AIDS/HIV	Y	N	?
h.	Increased bleeding or nosebleeds	Y	N	?
i.	Are you taking blood thinners	Y	N	?
j.	Chemotherapy or radiation treatment	Y	N	?
k.	Other blood/immune problems	Y	N	?

Explain_____

11. What Medications or other substances are you taking or have you taken in the past 2 months?

a. Please list all prescriptions and non-prescription drugs including aspirin, birth control pills, herbal medications or other supplements. Write "NONE" if you are not taking any medications or substances. _____

_____

_____

_____

_____

b. Have you ever taken or are you taking medicine for osteopenia, osteoporosis, bone loss Y N ?

i. **Example:** *Fosamax®, Actonel®, Boniva®, Reclast®, Evista®, Forteo®, Prolia®, Miacalin®, Fortical®*

c. Are you currently taking a **blood thinner**? Y N ?

i. **Example:** *Coumadin/Warfarin®, Eliquis®, Pradaxa®, Xarelto®, Heparin®, Aspirin®, Plavix®/Clopidogrel®*

ii. If taking Coumadin/Warfarin® what was your last INR? _____

d. When was your last visit to a physician (medical doctor)?_____

e. Please provide your physician's (medical doctor's) contact information.

i. Name: _____

ii. Location: _____

iii. Telephone Number: _____

Signature: _____ Date:_____

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f. Please provide your pharmacy's contact information.

i. Name: _____

ii. Location: _____

iii. Telephone Number: _____

12. Personal History

a. Have you ever been hospitalized, had major surgery or been seriously hurt? Y N ?

i. List: _____

_____

_____

_____

b. History of any sexually transmitted diseases (syphilis, gonorrhea, herpes, etc. HIV)? Y N ?

c. Do you need any special accommodations for dental treatment? Y N ?

i. Explain _____

d. Are you pregnant or breast feeding? Y N ?

e. Have you ever used tobacco products? Y N ?

f. Are you currently using tobacco products? Y N ?

Type and how much? _____

g. How many alcohol containing drinks do you consume a week? _____

h. Do you use or have you used recreational drugs? Y N ?

i. Have you ever had a problem with drugs and/or alcohol? Y N ?

j. Do you have mental health problems? Y N ?

OFFICE USE ONLY

Reviewed By: _____ Date: _____

_____

_____

_____

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_____

_____

Signature: _____ Date: _____

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DENTAL HISTORY

1. What is the reason for your dental visit? _____

Your Current Dental Health

2. Have you had a recent toothache? Y N ?
3. Are your teeth sensitive to hot, cold or pressure? Y N ?
4. Do you have bleeding gums? Y N ?
5. Do you have trouble chewing? Y N ?
6. Do you experience dry mouth? Y N ?
7. Do you have sores in or around your mouth? Y N ?
8. Do you clench or grind your teeth? Y N ?
9. Have you ever worn a bitesplint/nightguard? Y N ?
10. Please circle the amount of sugar in your diet? Small Moderate High
11. When was the last time your teeth were cleaned in a dental office? _____
12. How often do you brush? _____ Electric toothbrush Y N ?
13. How often do you floss? _____
14. Are you satisfied with the appearance of your teeth? _____
15. If not, what is one thing you would like to change about your teeth? _____

Previous Dental Treatment

16. Have you ever had any problems following dental treatment? Y N ?
    a. If yes, please explain _____
17. Have you ever had a "deep cleaning" or gum surgery? Y N ?
18. Have you ever had orthodontic treatment to straighten your teeth? Y N ?
19. Have you ever had extraction (pulling) of any teeth? Y N ?
20. Have you ever had endodontics (root canals) on any teeth? Y N ?
21. Have you had any missing teeth replaced by a removable denture, fixed bridge, or an implant? Y N ?
22. Have you ever had a bad or unusual reaction to local anesthetic? Y N ?
23. Have you ever had severe injury/surgery to your face, teeth, lips, or jaws? Y N ?
24. How do you feel about going to the dentist? No Problem Apprehensive Scared

Jaw Joint Health

25. Do you have difficulty opening your mouth as wide as you would like? Y N ?
26. Do your jaw joints or muscles hurt? Y N ?
27. Does your jaw click, pop or lock? Y N ?

Signature: _____ Date: _____