

Patient Name:

Birth Date:

Date Created:

Although dental personnel treat the area in and around your mouth, your mouth is part of your entire body. Health conditions or problems that you have or had, or medications that you may be taking

**ALLERGIES**

- |                                     |                                      |                                      |  |
|-------------------------------------|--------------------------------------|--------------------------------------|--|
| <input type="checkbox"/> Acrylics   | <input type="checkbox"/> Anaphalaxis | <input type="checkbox"/> Latex       | <input type="checkbox"/> Local Anesthetics |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Metal       | <input type="checkbox"/> Sulfa Drugs |  |

Other:  If yes \_\_\_\_\_

**CARDIOVASCULAR**

- |   |  |  |   |
|---|--|--|---|
| Artificial Heart/Valve <input type="radio"/> Yes <input type="radio"/> No | Coronary Artery Disease <input type="radio"/> Yes <input type="radio"/> No | Chest Pain or Angina <input type="radio"/> Yes <input type="radio"/> No  | Congestive Heart Failure <input type="radio"/> Yes <input type="radio"/> No |
| Heart Attack <input type="radio"/> Yes <input type="radio"/> No           | Heart Murmur <input type="radio"/> Yes <input type="radio"/> No            | High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No   | High Cholesterol <input type="radio"/> Yes <input type="radio"/> No         |
| Irregular Heart Beat <input type="radio"/> Yes <input type="radio"/> No   | Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No      | Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No | Pacemaker <input type="radio"/> Yes <input type="radio"/> No                |
| Tachycardia <input type="radio"/> Yes <input type="radio"/> No            |  |  |   |

**ENDOCRINE**

- |   |   |  |   |
|---|---|--|---|
| Diabetes <input type="radio"/> Yes <input type="radio"/> No | Gout <input type="radio"/> Yes <input type="radio"/> No | Hormonal Change <input type="radio"/> Yes <input type="radio"/> No | Thyroid Problems <input type="radio"/> Yes <input type="radio"/> No |
|---|---|--|---|

**EYES, EARS, NOSE and THROAT**

- |  |   |   |  |
|--|---|---|--|
| Change in Hearing <input type="radio"/> Yes <input type="radio"/> No | Change in Vision <input type="radio"/> Yes <input type="radio"/> No | Dysphagia <input type="radio"/> Yes <input type="radio"/> No          | Ear Pain <input type="radio"/> Yes <input type="radio"/> No      |
| Glaucoma <input type="radio"/> Yes <input type="radio"/> No          | Hay Fever <input type="radio"/> Yes <input type="radio"/> No        | Nasal Obstruction <input type="radio"/> Yes <input type="radio"/> No  | Nose Bleeding <input type="radio"/> Yes <input type="radio"/> No |
| Sinus Problems <input type="radio"/> Yes <input type="radio"/> No    | Tonsillectomy <input type="radio"/> Yes <input type="radio"/> No    | Tinnitus (Ringing) <input type="radio"/> Yes <input type="radio"/> No |  |

**GASTROINTESTINAL**

- |  |   |   |   |
|--|---|---|---|
| Acid Reflux <input type="radio"/> Yes <input type="radio"/> No | GERD <input type="radio"/> Yes <input type="radio"/> No | Soft or Special Diet <input type="radio"/> Yes <input type="radio"/> No | Ulcers <input type="radio"/> Yes <input type="radio"/> No |
|--|---|---|---|

**GENITOURINARY**

- |   |   |   |  |
|---|---|---|--|
| Frequent Urination <input type="radio"/> Yes <input type="radio"/> No | Kidney Disease <input type="radio"/> Yes <input type="radio"/> No | Nocturia <input type="radio"/> Yes <input type="radio"/> No |  |
|---|---|---|--|

**GENERAL**

- |  |   |   |  |
|--|---|---|--|
| Cancer <input type="radio"/> Yes <input type="radio"/> No          | Fatigue/Tired <input type="radio"/> Yes <input type="radio"/> No        | General Weakness <input type="radio"/> Yes <input type="radio"/> No | Headaches <input type="radio"/> Yes <input type="radio"/> No               |
| HIV/AIDS <input type="radio"/> Yes <input type="radio"/> No        | Knee/Hip Replacement <input type="radio"/> Yes <input type="radio"/> No | Liver Problems <input type="radio"/> Yes <input type="radio"/> No   | Recent Trauma or Injury <input type="radio"/> Yes <input type="radio"/> No |
| Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatment <input type="radio"/> Yes <input type="radio"/> No  | Weight Change <input type="radio"/> Yes <input type="radio"/> No    |  |

**HEMATOLOGICAL**

- |  |  |  |  |
|--|--|--|--|
| Bleeding Problems <input type="radio"/> Yes <input type="radio"/> No | Hepatitis <input type="radio"/> Yes <input type="radio"/> No |  |  |
|--|--|--|--|

**ORAL**

- |   |   |  |   |
|---|---|--|---|
| Bleeding Gums <input type="radio"/> Yes <input type="radio"/> No          | Dry Mouth <input type="radio"/> Yes <input type="radio"/> No                    | Jaw Problems (TMJ) <input type="radio"/> Yes <input type="radio"/> No    | Orthodontic/Invisalign <input type="radio"/> Yes <input type="radio"/> No |
| Periodontal Disease <input type="radio"/> Yes <input type="radio"/> No    | Teeth Clenching <input type="radio"/> Yes <input type="radio"/> No              | Teeth Grinding <input type="radio"/> Yes <input type="radio"/> No        | Tooth Pain <input type="radio"/> Yes <input type="radio"/> No             |
| Wisdom Teeth Extracted <input type="radio"/> Yes <input type="radio"/> No | Do you wear removable teeth? <input type="radio"/> Yes <input type="radio"/> No | Do you take a premed? <input type="radio"/> Yes <input type="radio"/> No |   |

**MUSCULOSKELETAL**

- |  |   |   |  |
|--|---|---|--|
| Back Pain <input type="radio"/> Yes <input type="radio"/> No | Fibromyalgia <input type="radio"/> Yes <input type="radio"/> No | Joint Pain <input type="radio"/> Yes <input type="radio"/> No |  |
|--|---|---|--|

**NEUROLOGICAL**

- |  |   |   |  |
|--|---|---|--|
| Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No     | Dizziness <input type="radio"/> Yes <input type="radio"/> No            | Fainting <input type="radio"/> Yes <input type="radio"/> No | Memory Loss <input type="radio"/> Yes <input type="radio"/> No |
| Multiple Sclerosis (MS) <input type="radio"/> Yes <input type="radio"/> No | Muscle Weakness <input type="radio"/> Yes <input type="radio"/> No      | Seizures <input type="radio"/> Yes <input type="radio"/> No | Stroke <input type="radio"/> Yes <input type="radio"/> No      |
| Tingling/Numbness <input type="radio"/> Yes <input type="radio"/> No       | Trigeminal Neuralgia <input type="radio"/> Yes <input type="radio"/> No | Tremor <input type="radio"/> Yes <input type="radio"/> No   |  |

**PSYCHIATRIC**

- |   |   |  |   |
|---|---|--|---|
| ADD/ADHD <input type="radio"/> Yes <input type="radio"/> No         | Anxiety <input type="radio"/> Yes <input type="radio"/> No          | Chemical Dependency <input type="radio"/> Yes <input type="radio"/> No | Depression <input type="radio"/> Yes <input type="radio"/> No |
| Eating Disorders <input type="radio"/> Yes <input type="radio"/> No | Excessive Stress <input type="radio"/> Yes <input type="radio"/> No | Memory Problems <input type="radio"/> Yes <input type="radio"/> No     |   |

**RESPIRATORY**

- |   |  |   |   |
|---|--|---|---|
| Asthma <input type="radio"/> Yes <input type="radio"/> No     | Bronchitis <input type="radio"/> Yes <input type="radio"/> No                    | Breathing Problems <input type="radio"/> Yes <input type="radio"/> No | Chest Pressure <input type="radio"/> Yes <input type="radio"/> No |
| Congestion <input type="radio"/> Yes <input type="radio"/> No | Dyspnea (shortness of breath) <input type="radio"/> Yes <input type="radio"/> No | Emphysema <input type="radio"/> Yes <input type="radio"/> No          | Orthopnea <input type="radio"/> Yes <input type="radio"/> No      |
| Pneumonia <input type="radio"/> Yes <input type="radio"/> No  | Pulmonary Embolism <input type="radio"/> Yes <input type="radio"/> No            | Tuberculosis <input type="radio"/> Yes <input type="radio"/> No       |   |

**SLEEP**

- |   |  |  |   |
|---|--|--|---|
| Daytime Sleepiness <input type="radio"/> Yes <input type="radio"/> No | Morning Headaches <input type="radio"/> Yes <input type="radio"/> No | Obstructive Sleep Apnea <input type="radio"/> Yes <input type="radio"/> No | Do you use a CPAP? <input type="radio"/> Yes <input type="radio"/> No |
| Do you snore? <input type="radio"/> Yes <input type="radio"/> No      |  |  |   |

**SOCIAL HISTORY**

- |  |  |  |   |
|--|--|--|---|
| Do you smoke? <input type="radio"/> Yes <input type="radio"/> No | Do you use smokeless tobacco? <input type="radio"/> Yes <input type="radio"/> No | Do you consume alcoholic beverages? <input type="radio"/> Yes <input type="radio"/> No | Do you use recreational drugs? <input type="radio"/> Yes <input type="radio"/> No |
|--|--|--|---|

Are you taking any medications?  Yes  No If yes \_\_\_\_\_

Have you had surgery or been hospitalized?  Yes  No If yes \_\_\_\_\_

Do you have any medical conditions or history not listed above?  Yes  No If yes \_\_\_\_\_

Primary Physician's Name:  Yes  No If yes \_\_\_\_\_

Are you under the care of other physicians?  Yes  No If yes \_\_\_\_\_

Signature of Patient, Parent or Guardian:

X

Date: \_\_\_\_\_