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

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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._____