USD Delta Dental Oral Health Center

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Health & Dental History

Patient Name: _____ Date: _____

Please complete the following Medical and Dental History form accurately to the best of your knowledge until you see STOP.

Physician and Pharmacy Information

Family doctor

Family doctor #

Preferred pharmacy

Pharmacy #

Medical History

- [ ] Are you seeing a physician at this time?

Date of last physical exam

- [ ] Have you had a serious illness, operation or been hospitalized in the past 5 years?
- [ ] Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?
- [ ] Have you ever had a heart valve replacement?
- [ ] Have you ever had any transplants (kidney, etc)?

- [ ] Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

- [ ] Are you pregnant?

- [ ] Are you nursing?

- [ ] Have you been treated for alcohol or drug abuse? When was treatment completed?

- [ ] Do you use tobacco (smoking, snuff, chew, bidis)?

- [ ] Are you HIV+ or have AIDS?

Conditions

- [ ] AIDS or HIV infection
- [ ] Anxiety
- [ ] Arthritis
- [ ] Asthma
- [ ] Autoimmune disease
- [ ] Bacterial Endocarditis
- [ ] Breathing problems/ respiratory disease
- [ ] Cancer/chemotherapy/ radiation treatment
- [ ] Cardiovascular disease
- [ ] Cholesterol
- [ ] Congestive heart failure
- [ ] COPD
- [ ] Damaged heart valves
- [ ] Depression
- [ ] Diabetes
- [ ] Digestive Disorders (celiac, Crohn's, etc)
- [ ] Eating disorder
- [ ] Epilepsy
- [ ] Fainting spells or seizures
- [ ] G.E. Reflux/persistent heartburn
- [ ] Heart attack
- [ ] Hemophilia
- [ ] Hepatitis, jaundice or liver disease
- [ ] High blood pressure
- [ ] Kidney problems
- [ ] Mitral valve prolapse
- [ ] Neurological disorders
- [ ] Osteopenia
- [ ] Osteoporosis/Paget's disease
- [ ] Other congenital heart defects
- [ ] Pacemaker
- [ ] Pregnant
- [ ] Rheumatoid arthritis
- [ ] Seasonal allergies
- [ ] Stroke
- [ ] Synthetic or Artificial Joints
- [ ] Thyroid problems
- [ ] TMJ Disorder
- [ ] Tuberculosis
- [ ] Ulcers

- [ ] Do you have any other disease, condition, or problem not listed above?

Allergies

Allergies

- [ ] Aspirin
- [ ] Hay fever/seasonal
- [ ] Latex
- [ ] Local anesthetic
- [ ] Penicillin
- [ ] Sulfa
- [ ] Other

Dental History

- [ ] What is the name and location of your current dentist?
- [ ] When was your last dental visit? What was this visit for?
- [ ] Is there anything about having dental treatment that bothers you?
- [ ] Are you currently experiencing dental pain or discomfort?
- [ ] Have you ever had orthodontic (braces) treatment?
- [ ] Have you had any oral surgery or extractions? If yes, did you have excessive bleeding following the procedure?
- [ ] Have you had any periodontal (gum) treatment?
- [ ] Have you had any radiation therapy to the head or neck?
- [ ] Do you have any sores or ulcers in your mouth?

Health & Dental History

- [ ] Do you grind your teeth?
- [ ] Do you have any clicking, popping or discomfort in your jaw?
- [ ] Have you ever had a serious injury to your head, neck or mouth?
- [ ] Do you have earaches or neck pains?
- [ ] Are your teeth sensitive to cold, hot, sweets, or pressure?
- [ ] Do your gums bleed when you brush or floss?
- [ ] Does food or floss catch between your teeth?
- [ ] How often do you brush your teeth? Do you use a manual or electric toothbrush?

- [ ] Are you able to floss or clean between your teeth? How often?

- [ ] Do you use any other devices to clean your teeth (mouthrinse, waterpik, sensitivity toothpaste, etc.)?

- [ ] Do you have sleep apnea?
- [ ] Do you wear any snore appliances or a CPAP?

- [ ] Have you had any radiographs in the last year? Type?
