

Date: _____

Patient #: _____

Date of Birth: _____

Age: _____ Sex: _____

Cell Phone: _____

Work Phone: _____

Home Phone: _____

University Health Center Dental Office

Name: _____

Other Name/Nickname: _____
Last First Middle

Local Address: _____

Medical History

- Yes No Have you been under the care of a medical doctor during the past two years?
Name and address of your physician: _____
- Yes No Are you currently under care for a specific illness?
If yes, please explain: _____
- Yes No Have you been hospitalized or had a serious illness within the past two (2) years?
If yes, be specific: _____
- Yes No Have you ever taken any medication for osteoporosis, bisphosphonate therapy or antiresorptive therapy?
If yes, oral or IV? _____ Name and for how long? _____
- Yes No Have you ever taken any diet pills/weight reduction medication (Fen-Phen, Dexfenfluramine)?
If yes, please list: _____

Please list all medications you take daily, including prescription medications, over-the-counter, vitamins and herbal supplements. Include the dosage and how often you take your medicine.

Name of Medication	Dose	Frequency

Do you have or have you had:

- Yes No Heart infection (Bacterial Endocarditis)?
- Yes No Artificial heart valve?
- Yes No Congenital heart defect?
- Yes No High blood pressure?
- Yes No Swelling of feet or ankles?
- Yes No Chest pains?
- Yes No Breathing problems (i.e. shortness of breath)?
- Yes No Asthma – Allergy or exercise induced? If yes, please explain: _____
- Yes No Seasonal allergies (Hay Fever, etc.)?
- Yes No Sinus infections?
- Yes No Anemia/bleeding disorders?
- Yes No Stomach or digestive trouble? If yes, please explain: _____
- Yes No Hepatitis or liver problems? If yes, please explain type: _____
- Yes No AIDS, ARC, HIV, ANIT-HIV? If yes, please circle/explain: _____
- Yes No Sexually transmitted diseases (STDs)? Type: _____
- Yes No Tuberculosis (TB)?
- Yes No Diabetes I or II?
- Yes No Kidney or urinary problems (i.e. stones, frequent urination, UTI)? If yes, please circle.
- Yes No Cancer or tumor? If yes, please explain: _____

Name: _____ Patient #: _____

Do you have or have you had:

- Yes No Radiation therapy (for cancer or tumor)? If yes, dates of treatment: _____
- Yes No Chemotherapy (for cancer or tumor)? If yes, dates of treatment: _____
- Yes No Convulsions, seizures, epilepsy or fainting? If so, what causes: _____
- Yes No Arthritis, rheumatism?
- Yes No Joint replacement? If yes, name of joint and date of operation/replacement: _____
- Yes No Endocrine disturbances (i.e. thyroid disease, etc.)?
- Yes No Psychological or emotional problems (i.e., anxiety, depression, ADHD, Eating Disorder, etc.)? _____
- Yes No Frequent headaches?
- Yes No Do you have any disease, conditions or problem not listed above that we should know about?
If so, explain: _____
- Yes No Do you smoke, vape or use smokeless tobacco products such as chewing tobacco?
- Yes No Do you drink alcohol? If yes, how many drinks per week? _____
- Yes No Have you ever used/or do you use recreational drugs? If yes, please list: _____
- Yes No Are you in rehab for drug use?
- Yes No Have you been vaccinated for HPV?

Are you allergic to or had a reaction to any of the following?

- | | |
|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Local anesthetic (Novocain, etc.) | <input type="checkbox"/> Yes <input type="checkbox"/> No Aspirin |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Penicillin or other antibiotics | <input type="checkbox"/> Yes <input type="checkbox"/> No Iodine |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Sulfa drugs | <input type="checkbox"/> Yes <input type="checkbox"/> No Codeine/other narcotics |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Latex | <input type="checkbox"/> Yes <input type="checkbox"/> No Metals |

Other allergies: _____

If you answered yes to any of these questions, please note type of reaction: _____

Females

- Yes No Are you pregnant? If so, what trimester? _____
- Yes No Are you using a form of birth control? If so, please list: _____
- Yes No Have you been through menopause?

Dental History

How long since you have been to a dentist? _____

What was done at your last visit? _____

- Yes No Were dental X-ray films taken?
- Yes No Are you having discomfort at this time? Explain: _____
- Yes No Are any of your teeth sensitive to any of the following: Heat, cold, sweets?
- Yes No Have you ever had your teeth straightened (Braces)?
- Yes No Do you have a dental implant?
- Yes No Have you ever had a gum infection?
- Yes No Have you had previous periodontal treatment (gum treatment or graft)?
- Yes No Do your gums bleed when you brush?
- Yes No Do you have an unpleasant taste in your mouth?
- Yes No Do you have bad breath?
- Yes No Do you grind or clench your teeth?
- Yes No Do you eat between meals? If yes, what? _____
- How often do you brush your teeth? _____
- What type of brush do you use? ___Electric ___Manual
- What type of bristles in your brush? ___Hard ___Medium ___Soft
- Brushing technique _____ Oral habit (e.g. nail biting, pencil chewing) _____
- Yes No Additional cleaning aids (Floss, stimulator, irrigator, other)?
- What do you think of your teeth? _____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health or medications, I will inform the office at my next appointment. I understand that I am financially responsible for all charges, whether covered or denied by my insurance company.

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____