UNIVERSITY HEALTH CENTER
by Nebraska Medicine

UNIVERSITY OF Nebraska Lincoln

University Health Center Dental Office

Date: ____________________________

Patient #: ________________________

Date of Birth: _____________________

Age: __________ Sex: ____________

Cell Phone: ______________________

Work Phone: _____________________

Home Phone: _____________________

Name: ____
Last First Middle

Other Name/Nickname: ____

Local Address: ____

____

Medical History (please circle correct answer)

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 (Fosamax, Boniva, Actonel, Reclast)?
If yes, please circle. 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** Bisphosphonate therapy? If yes, have you taken Aredia or Zometa? How long? ______________
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?
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: __________
____

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

Yes **No** Local anesthetic (Novocain, etc.)
Yes **No** Penicillin or other antibiotics
Yes **No** Sulfa drugs
Yes **No** Latex
Yes **No** Aspirin
Yes **No** Iodine
Yes **No** Codeine or other narcotics
Yes **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 smoke or use smokeless tobacco products such as chewing tobacco?
Yes **No** Do you drink alcohol? If yes, how many drinks per week? ______________
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 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: ______________

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