Preferred Name: _____ **Email:** _____ **Today's date:** _____

Name: _____
Last, First, MI

If you are completing this form for another person, what is your relationship to that person?

Your name: _____ Relationship _____

Do you currently have any of the following diseases or problems:	**YES**	**NO**
Active Tuberculosis	☐	☐
Persistent cough greater than a 3 week duration	☐	☐
Cough that produces blood	☐	☐
Been exposed to anyone with tuberculosis	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

DENTAL INFORMATION

For the following questions, please mark ☒ your responses to the following questions.

☐ Do your gums bleed when you brush or floss?
☐ Are your teeth sensitive to cold, hot, sweets or pressure?
☐ Does food or floss catch between your teeth?
☐ Is your mouth dry?
☐ Have you had any periodontal (gum) treatments?
☐ Have you ever had orthodontic (braces) treatment?
☐ Have you had any problems associated with previous dental treatment?
☐ Is your home water supply fluoridated?
☐ Do you drink bottled or filtered water?
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY
☐ Are you currently experiencing dental pain or discomfort?

☐ Do you have earaches or neck pains?
☐ Do you have any clicking, popping or discomfort in the jaw?
☐ Do you brux or grind your teeth?
☐ Do you have sores or ulcers in your mouth?
☐ Do you wear dentures or partials?
☐ Do you participate in active recreational activities?
☐ Have you ever had a serious injury to your head or mouth?
Date of your last dental exam: _____
Date of last dental x-rays: _____
What was done at that time? _____
_____
What is the reason for your visit?

How do you like your smile? (Please circle all that apply)

A. I think the appearance of my smile is excellent.
B. I am satisfied with the appearance of my smile.
C. I am dissatisfied with the appearance of my smile.

A. I do exactly as instructed for my dental health.
B. I usually do what the dentist recommends for my dental health.
C. I rarely go to the dentist and don't care much about my mouth.

A. I have set goals for my oral health with a previous dentist.
B. I want to set goals concerning my oral health.
C. I never set goals concerning my oral health.

A. I enjoy going to the dentist and having my teeth cleaned.
B. I don't enjoy going to the dentist.
C. I am apprehensive and sometimes scared going to the dentist.

A. I will do anything to keep my natural teeth.
B. I want to keep my natural teeth, but have a certain budget of time and money.
C. I don't care whether I keep my teeth or not.

MEDICAL INFORMATION

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you now under the care of a physician? Yes ☐ No ☐
Physician Name: _____
Phone: (_____) _____
Address/City/State/Zip: _____
_____

Are you in good health? Yes ☐ No ☐
Has there been any change in your general health within the past year? Yes ☐ No ☐
If yes, what condition is being treated? _____
_____
Date of last physical exam:

Have you had a serious illness, operation or been hospitalized in the past 5 years? Yes ☐ No ☐
If yes, what was the illness or problem: _____
_____
_____

Are you taking or have you recently taken any prescription or over the counter medicine(s)? Yes ☐ No ☐
If so, please list **ALL**, including vitamins, natural or herbal preparations and/or diet supplements: _____
_____
_____

Carolinas Center for Oral Health

Dental and Medical History Form

4905 (1/10)

Patient Information or Label

Name:

DOB:

Medical Record #:

Job: CP6821
J0106886
4905
2nd proof: 1/15/10
Ink: Black
Paper: 20# Canary
FACE

Medical Information Please mark ☒ your response to indicate if you have or had any of the following.

☐ Do you wear contact lenses?
☐ Are you currently taking a blood thinner? If yes, please explain: _____
☐ Are you taking, have you taken or are you scheduled to take any oral or IV Bisphosphonates? If yes, please explain: _____
☐ Have you had any problems or complications with any surgeries or anesthesia? If yes, please explain: _____
☐ Do you use controlled substances (drugs)? If yes, please explain: _____
☐ Do you use/used tobacco (smoking, snuff, chew)? If so, how much? _____ # of years? _____ Year quit? _____
☐ Alcohol: Daily / Weekly / Rarely / Never If yes, how much alcohol did you drink in the last 24 hours? _____

WOMEN ONLY: Are you ☐ Pregnant/trying to get pregnant? ☐ Taking oral contraceptives? ☐ Hormonal replacement? ☐ Nursing?

Allergies – Are you allergic to or have you had a reaction to: Mark an ☒ to all that apply, specify type of reaction.

☐ Local anesthetics
☐ Aspirin / NSAIDs (Ibuprofen)
☐ Amoxicillin/Penicillin
☐ Barbiturates, sedatives, or sleeping pills
☐ Codeine or other narcotics
☐ Iodine
☐ Metals
☐ Latex (rubber)
☐ Hay fever/seasonal
☐ Sulfa drugs
☐ Animals
☐ Food _____
☐ Other: _____

Please ☒ a response to indicate if you have or had any of the following diseases or problems.

☐ Artificial (prosthetic) heart valve
☐ Previous infective endocarditis
☐ Damaged valves in transplanted heart
☐ Congenital heart disease (CHD) / Defect
  ☐ Unrepaired, cyanotic CHD
  ☐ Repaired (completely) in last 6 months
  ☐ Repaired CHD with residual defects

☐ JOINT REPLACEMENT. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? Yes ☐ No ☐
Date: _____ If yes, have you had any complications? _____

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of

☐ Abnormal bleeding
☐ AIDS or HIV infection
☐ Anemia
☐ Arthritis / Osteoarthritis / Rheumatoid
☐ Asthma / Difficulty breathing / Shortness of breath
☐ Autoimmune disease
☐ Skin Lesions
☐ Blood transfusions. If yes, date _____
☐ Cancer/Chemotherapy/Radiation Treatment
☐ Cardiovascular disease. If yes, specify below:
___ Angina
___ Arteriosclerosis
___ Congestive heart failure
___ Coronary artery disease
___ Heart attack
___ Heart murmur
___ Stroke
___ High blood pressure
___ Low blood pressure
___ Mitral valve prolapse
___ Pacemaker
___ Rheumatic heart disease/Rheumatic fever
___ Scarlet fever

☐ Chest pain
☐ Chronic pain - where? _____
☐ Diarrhea
☐ Diabetes. If yes, specify below:
___ Type I (insulin dependent) ___ Type II
☐ Depression / Anxiety / Nervousness
☐ Dry Eyes
☐ Dry Mouth
☐ Eating disorder. If yes, specify below:
___ Anorexia ___ Bulimia
☐ Epilepsy
☐ Fainting spells or seizures
☐ Gastrointestinal disease
☐ G.E. Reflux/persistent heartburn
☐ Glaucoma
☐ Herpes / Fever blisters
☐ Hemophilia
☐ Hepatitis A, B or C
☐ Jaundice or liver disease
☐ Recurrent infections
☐ Joint pain
☐ Kidney problems / Dialysis
☐ Leukemia
☐ Lung disease
☐ Respiratory problems
___ Emphysema ___ Bronchitis
☐ Mental health disorders.
If yes, specify: _____
☐ Malnutrition
☐ Nausea
☐ Vomiting
☐ Night sweats
☐ Neurological disorders.
If yes, specify: _____
☐ Organ transplant
☐ Osteoporosis
☐ Persistent swollen glands in neck
☐ Severe headaches/migraines
☐ Severe or rapid weight loss
☐ Sexually transmitted disease
☐ Shingles
☐ Sinus trouble
☐ Sleep disorder
☐ Sores or ulcers in mouth
☐ Stemcell transplant
☐ Stomach problems / ulcer
☐ Systemic lupus erythematosus
☐ Tuberculosis
☐ Thyroid problems
☐ Tumors / Growths
☐ Excessive urination

Do you have any disease, condition, or problem not listed above that we should know about?
Please Explain: _____
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Yes ☐ No ☐
Name of physician or dentist making recommendation: _____ **Phone:** _____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient / Legal Guardian: **Date:**

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BACK
prints Head to Head