

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	<input type="checkbox"/>	<input type="checkbox"/>
Persistent cough greater than a 3 week duration	<input type="checkbox"/>	<input type="checkbox"/>
Cough that produces blood	<input type="checkbox"/>	<input type="checkbox"/>
Been exposed to anyone with tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>

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.

<input type="checkbox"/> Do your gums bleed when you brush or floss?	<input type="checkbox"/> Do you have earaches or neck pains?
<input type="checkbox"/> Are your teeth sensitive to cold, hot, sweets or pressure?	<input type="checkbox"/> Do you have any clicking, popping or discomfort in the jaw?
<input type="checkbox"/> Does food or floss catch between your teeth?	<input type="checkbox"/> Do you brux or grind your teeth?
<input type="checkbox"/> Is your mouth dry?	<input type="checkbox"/> Do you have sores or ulcers in your mouth?
<input type="checkbox"/> Have you had any periodontal (gum) treatments?	<input type="checkbox"/> Do you wear dentures or partials?
<input type="checkbox"/> Have you ever had orthodontic (braces) treatment?	<input type="checkbox"/> Do you participate in active recreational activities?
<input type="checkbox"/> Have you had any problems associated with previous dental treatment?	<input type="checkbox"/> Have you ever had a serious injury to your head or mouth?
<input type="checkbox"/> Is your home water supply fluoridated?	Date of your last dental exam: _____
<input type="checkbox"/> Do you drink bottled or filtered water?	Date of last dental x-rays: _____
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY	What was done at that time? _____
<input type="checkbox"/> Are you currently experiencing dental pain or discomfort?	_____
	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.	A. I do exactly as instructed for my dental health.
B. I am satisfied with the appearance of my smile.	B. I usually do what the dentist recommends for my dental health.
C. I am dissatisfied with the appearance of my smile.	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.	A. I enjoy going to the dentist and having my teeth cleaned.
B. I want to set goals concerning my oral health.	B. I don't enjoy going to the dentist.
C. I never set goals concerning my oral health.	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 <input type="checkbox"/> No <input type="checkbox"/>	Have you had a serious illness, operation or been hospitalized in the past 5 years? Yes <input type="checkbox"/> No <input type="checkbox"/>
Physician Name: _____	If yes, what was the illness or problem: _____
Phone: ( _____ ) _____	_____
Address/City/State/Zip: _____	_____
_____	_____
Are you in good health? Yes <input type="checkbox"/> No <input type="checkbox"/>	Are you taking or have you recently taken any prescription or over the counter medicine(s)? Yes <input type="checkbox"/> No <input type="checkbox"/>
Has there been any change in your general health within the past year? Yes <input type="checkbox"/> No <input type="checkbox"/>	If so, please list <b>ALL</b> , including vitamins, natural or herbal preparations and/or diet supplements: _____
If yes, what condition is being treated? _____	_____
_____	_____
Date of last physical exam: _____	_____



Carolinan Center for Oral Health  
Dental and Medical History Form

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.

- |   |   |                                       |
|---|---|---------------------------------------|
| <input type="checkbox"/> Local anesthetics                          | <input type="checkbox"/> Metals             | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Aspirin / NSAIDs (Ibuprofen)               | <input type="checkbox"/> Latex (rubber)     |                                       |
| <input type="checkbox"/> Amoxicillin/Penicillin                     | <input type="checkbox"/> Hay fever/seasonal |                                       |
| <input type="checkbox"/> Barbiturates, sedatives, or sleeping pills | <input type="checkbox"/> Sulfa drugs        |                                       |
| <input type="checkbox"/> Codeine or other narcotics                 | <input type="checkbox"/> Animals            |                                       |
| <input type="checkbox"/> Iodine                                     | <input type="checkbox"/> Food _____         |                                       |

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**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Abnormal bleeding                                   | <input type="checkbox"/> Dry Eyes  | <input type="checkbox"/> Malnutrition                      |
| <input type="checkbox"/> AIDS or HIV infection                               | <input type="checkbox"/> Dry Mouth   | <input type="checkbox"/> Nausea                            |
| <input type="checkbox"/> Anemia  | <input type="checkbox"/> Eating disorder. If yes, specify below:<br>___ Anorexia ___ Bulimia | <input type="checkbox"/> Vomiting                          |
| <input type="checkbox"/> Arthritis / Osteoarthritis / Rheumatoid             | <input type="checkbox"/> Epilepsy  | <input type="checkbox"/> Night sweats                      |
| <input type="checkbox"/> Asthma / Difficulty breathing / Shortness of breath | <input type="checkbox"/> Fainting spells or seizures   | <input type="checkbox"/> Neurological disorders.           |
| <input type="checkbox"/> Autoimmune disease                                  | <input type="checkbox"/> Gastrointestinal disease  | If yes, specify: _____                                     |
| <input type="checkbox"/> Skin Lesions  | <input type="checkbox"/> G.E. Reflux/persistent heartburn                                    | <input type="checkbox"/> Organ transplant                  |
| <input type="checkbox"/> Blood transfusions. If yes, date _____              | <input type="checkbox"/> Glaucoma  | <input type="checkbox"/> Osteoporosis                      |
| <input type="checkbox"/> Cancer/Chemotherapy/Radiation Treatment             | <input type="checkbox"/> Herpes / Fever blisters   | <input type="checkbox"/> Persistent swollen glands in neck |
| <input type="checkbox"/> Cardiovascular disease. If yes, specify below:      | <input type="checkbox"/> Hemophilia  | <input type="checkbox"/> Severe headaches/migraines        |
| ___ Angina   | <input type="checkbox"/> Hepatitis A, B or C   | <input type="checkbox"/> Severe or rapid weight loss       |
| ___ Arteriosclerosis   | <input type="checkbox"/> Jaundice or liver disease   | <input type="checkbox"/> Sexually transmitted disease      |
| ___ Congestive heart failure   | <input type="checkbox"/> Recurrent infections  | <input type="checkbox"/> Shingles                          |
| ___ Coronary artery disease  | <input type="checkbox"/> Joint pain  | <input type="checkbox"/> Sinus trouble                     |
| ___ Heart attack   | <input type="checkbox"/> Kidney problems / Dialysis  | <input type="checkbox"/> Sleep disorder                    |
| ___ Heart murmur   | <input type="checkbox"/> Leukemia  | <input type="checkbox"/> Sores or ulcers in mouth          |
| ___ Stroke   | <input type="checkbox"/> Lung disease  | <input type="checkbox"/> Stemcell transplant               |
|  | <input type="checkbox"/> Respiratory problems  | <input type="checkbox"/> Stomach problems / ulcer          |
|  | ___ Emphysema ___ Bronchitis   | <input type="checkbox"/> Systemic lupus erythematosus      |
| <input type="checkbox"/> Chest pain  | <input type="checkbox"/> Mental health disorders.  | <input type="checkbox"/> Tuberculosis                      |
| <input type="checkbox"/> Chronic pain - where? _____                         | If yes, specify: _____   | <input type="checkbox"/> Thyroid problems                  |
| <input type="checkbox"/> Diarrhea  |  | <input type="checkbox"/> Tumors / Growths                  |
| <input type="checkbox"/> Diabetes. If yes, specify below:                    |  | <input type="checkbox"/> Excessive urination               |
| ___ Type I (insulin dependent) ___ Type II                                   |  |  |
| <input type="checkbox"/> Depression / Anxiety / Nervousness                  |  |  |

**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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