CAROLINA FAMILY HEALTH CENTERS, INC.

Carolina Family Dental Center • Freedom Hill Community Health Center• Harvest Family Health Center •Wilson Community Health Center

Dental Health History

MEDICAL INFORMATION

Name of your medical doctor(s): _____

Date of last visit to medical doctor: _____

Please mark (X) your response to indicate if you <u>currently</u> have any of the following:

	YES	NO		YES	NO
Active Tuberculosis	☐	☐	Difficulty Breathing	☐	☐
Persistent, productive cough	☐	☐	Severe or Rapid Weight Loss	☐	☐
Intravenous bisphosphonate treatment	☐	☐	Overnight hospitalization	☐	☐
Chest pain	☐	☐	Fever/Chills	☐	☐

Please mark (X) your response to indicate if you have had any of the following diseases or problems.

	YES	NO		YES	NO
Artificial, Damaged, or Repaired Heart Valve	☐	☐	Cancer/Chemotherapy/Radiation	☐	☐
Infective Endocarditis	☐	☐	If yes, specify: _____		
Joint Replacement	☐	☐	Diabetes	☐	☐
If yes, date: _____			If yes, specify type: _____		
Congestive Heart Failure	☐	☐	Reflux/Heartburn	☐	☐
Heart Attack	☐	☐	Thyroid Problems	☐	☐
Stroke	☐	☐	Hepatitis, jaundice, or liver disease	☐	☐
Heart Murmur	☐	☐	Epilepsy/Seizures	☐	☐
High Blood Pressure	☐	☐	Severe Headaches/Migraines	☐	☐
Pacemaker/Defibrillator	☐	☐	Sleep Disorder	☐	☐
Abnormal Bleeding	☐	☐	Mental Health Disorder	☐	☐
Anemia	☐	☐	If yes, specify: _____		
HIV Infection	☐	☐	Kidney Problems	☐	☐
Arthritis (joint pain)	☐	☐	If yes, specify: _____		
Osteoporosis (thin bones)	☐	☐	Sexually Transmitted Disease	☐	☐
Rheumatoid Arthritis	☐	☐	If yes, specify: _____		
Asthma	☐	☐	Are you Pregnant?	☐	☐
COPD (Emphysema/Bronchitis)	☐	☐	Number of Weeks: _____		
History of chronic sinus infections	☐	☐	Are you nursing?	☐	☐

Other disease, condition, problem not listed above:

_____

ALLERGIES

Please mark (X) to indicate if you are allergic to or have had a reaction to any of the following:

	YES	NO		YES	NO
Local Anesthetics	☐	☐	Metals	☐	☐
Penicillin	☐	☐	Latex (rubber)	☐	☐
Sulfa Drugs	☐	☐	Iodine	☐	☐
Aspirin or other NSAIDs	☐	☐	Others not listed: _____		

MEDICATIONS

Are you taking any of the following medications?

	YES	NO		YES	NO
Blood Thinners	☐	☐	Medications for bone health	☐	☐

List all medications you are currently taking (prescription and non-prescription/over-the-counter)*:*

_____

_____

_____

_____

CAROLINA FAMILY HEALTH CENTERS, INC.

Carolina Family Dental Center • Freedom Hill Community Health Center• Harvest Family Health Center •Wilson Community Health Center

Dental Health History

SOCIAL HISTORY

	YES	NO
Do you use recreational drugs?	☐	☐
Do you drink alcoholic beverages?	☐	☐

	YES	NO
Do you use tobacco?	☐	☐

Type: _____

Number of years of use: ____

DENTAL HISTORY

What is the reason for your dental visit today? _____

Date of Last Dental Exam: _____

Are you <u>currently</u> experiencing any of the following:

	YES	NO
Tooth pain or discomfort	☐	☐
Tooth sensitivity	☐	☐
Broken or chipped tooth	☐	☐
Problems with gums	☐	☐
Problems with dentures/false teeth	☐	☐

	YES	NO
Bad breath	☐	☐
Sores or ulcers in or around your mouth	☐	☐
Swelling in or around your mouth	☐	☐
Pain in your jaw and/or jaw joint	☐	☐

Please mark (X) your responses to the following questions:

	YES	NO
Do your gums bleed when you brush or floss?	☐	☐
Is your mouth dry?	☐	☐
Have you ever had orthodontic treatment (braces)?	☐	☐
Have you ever had any problems associated with previous dental treatment?	☐	☐
Is your home water supply fluoridated?	☐	☐
Do you drink bottled or filtered water?	☐	☐
Do you have any clicking, popping, or discomfort in the jaw?	☐	☐
Do you clench or grind your teeth?	☐	☐
Do you wear dentures or partials?	☐	☐
Do you participate in sports?	☐	☐
Have you ever had a serious injury to your head, mouth, or teeth?	☐	☐

I understand that the information I am providing is important to my treatment. I certify that the information is true to the best of my knowledge.

_____ _____

Patient's Name (printed) *DOB*

_____ _____

Patient's Signature *Date*

Parent or Legal Guardian Signature (if patient is under 18 years old)

CAROLINA FAMILY HEALTH CENTERS, INC.

Carolina Family Dental Center • Freedom Hill Community Health Center• Harvest Family Health Center •Wilson Community Health Center

Dental Health History

Has there been any change in your health history since your last dental visit?

☐ **YES** ☐ **NO**

If yes, for what conditions:

_____

_____

_____

Have your medications changed since your last dental visit?

☐ **YES** ☐ **NO**

If yes, what changes have been made:

_____

_____

_____

Do you have any allergies or adverse reactions to any medications?

☐ **YES** ☐ **NO**

If yes, what:

_____

_____

_____

I understand that the information I am providing is important to my treatment. I certify that the information is true to the best of my knowledge.

_____ _____

Patient's Name (printed) *DOB*

_____ _____

Patient's Signature *Date*

Parent or Legal Guardian Signature (if patient is under 18 years old)