

# Medical and Dental Questionnaire

Dental Record Number _____
Patient Name (Last, First, MI) _____
Date of Birth (MM/DD/YYYY) _____

Mark your response to indicate if you have had any of the following diseases or problems.  
 Mark **don't know (DK)** if you are unsure whether you have had the disease or problem.  
 If you have a disease or problem that is not listed below, write the disease or condition in the space at the bottom of this form.

Do you have tuberculosis?	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>	Physician: Name _____ Telephone _____
Are you pregnant?	Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>	Address: _____

Date of last physical examination: _____  Yes No DK <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Any changes in your health within the past year?	Yes No DK <b>Immune</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Past use of steroids <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Delayed healing  Yes No DK <b>Musculoskeletal</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Arthritis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Artificial joint <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lupus <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sjogren's Syndrome <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Osteoporosis  Yes No DK <b>Gastrointestinal</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Acid reflux/GERD <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Irritable bowel syndrome <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Stomach ulcer  Yes No DK <b>Hepatic</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Liver disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Jaundice <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hepatitis  Yes No DK <b>Neurologic</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Epilepsy/seizures <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Headaches  Yes No DK <b>Skin</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hives or skin rash <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other skin lesions  Yes No DK <b>Eyes/Ears</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Glaucoma <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Impaired vision <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Impaired hearing	Yes No DK <b>Mental Health</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bipolar disorder <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Depression <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Anxiety <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Eating disorders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sleep disorder <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dementia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Learning disorders  Yes No DK <b>Infections</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> HIV positive/AIDS <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sexually transmitted disease  Yes No DK <b>Allergies</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Local anesthetic <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Antibiotics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Aspirin/ibuprofen <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Acetaminophen (Tylenol) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Codeine/narcotics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Metals <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Latex <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other: _____  Yes No DK <b>Other</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cancer <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cancer treatment <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nursing infant <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tobacco use <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Alcohol use <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chemical dependency <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Street/recreational/illicit drug use
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Please list any disease, condition, or problem you have that is not listed above.  
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 \_\_\_\_\_

Please list any hospitalizations or surgeries you have had.  
 \_\_\_\_\_  
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(Please continue on opposite side)

**Dental Information**

<p><b>Yes No</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Is it important for you to keep your teeth?</p> <p><input type="checkbox"/> <input type="checkbox"/> Are you satisfied with the appearance of your teeth?</p> <p><input type="checkbox"/> <input type="checkbox"/> Are you satisfied with the function of your teeth?</p> <p><input type="checkbox"/> <input type="checkbox"/> Does food frequently get caught between teeth?</p> <p><input type="checkbox"/> <input type="checkbox"/> Do your gums often bleed while brushing?</p> <p><input type="checkbox"/> <input type="checkbox"/> Have you noticed loosening of your teeth?</p> <p><input type="checkbox"/> <input type="checkbox"/> Have you injured your head, neck, or jaw?</p> <p><input type="checkbox"/> <input type="checkbox"/> Do you have difficulty eating or swallowing?</p> <p><input type="checkbox"/> <input type="checkbox"/> Do you have a dry mouth?</p> <p><input type="checkbox"/> <input type="checkbox"/> Have you had a change in your ability to taste foods?</p> <p><b>Yes No</b> Problems of the jaw – Have you noticed:</p> <p><input type="checkbox"/> <input type="checkbox"/> Clicking of the jaw?</p> <p><input type="checkbox"/> <input type="checkbox"/> Pain (joint, ear, side of face)?</p> <p><input type="checkbox"/> <input type="checkbox"/> Difficulty opening or closing?</p> <p><input type="checkbox"/> <input type="checkbox"/> Difficulty chewing?</p> <p><b>Yes No</b> Oral habits: Do you:</p> <p><input type="checkbox"/> <input type="checkbox"/> Clench or grind your teeth?</p> <p><input type="checkbox"/> <input type="checkbox"/> Bite your lips or cheek frequently?</p>	<p><b>Yes No</b> Have you had:</p> <p><input type="checkbox"/> <input type="checkbox"/> Orthodontic treatment (braces)?</p> <p><input type="checkbox"/> <input type="checkbox"/> Oral surgery?</p> <p><input type="checkbox"/> <input type="checkbox"/> Gum treatment?</p> <p><input type="checkbox"/> <input type="checkbox"/> Your bite adjusted?</p> <p><input type="checkbox"/> <input type="checkbox"/> A bite plane/guard or other appliance?</p> <p><b>Yes No</b> Do you currently have:</p> <p><input type="checkbox"/> <input type="checkbox"/> Dental pain?</p> <p><input type="checkbox"/> <input type="checkbox"/> Sores or swellings in your mouth?</p> <p><input type="checkbox"/> <input type="checkbox"/> A partial/full denture or dental implants?</p> <p><input type="checkbox"/> <input type="checkbox"/> Do you supplement your diet with fluoride?</p> <p><input type="checkbox"/> <input type="checkbox"/> Have you had any difficulty with dental treatment?</p> <p>Date of last dental x-rays _____</p> <p>How often do you brush your teeth? _____</p> <p>How often do you floss? _____</p> <p>Date of last dental treatment: _____</p> <p>Date of last teeth cleaning: _____</p> <p><b>Reason for today's dental visit?</b> _____</p>
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**Please explain if you answered "Yes" to, or are uncertain about, any of the above items.**

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To the best of my knowledge, the preceding information is complete and correct.

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**Signature – Patient (or parent/guardian if patient is under 18)** \_\_\_\_\_  
**Date**

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**MEDICAL UPDATES**

I have reviewed my Health History and confirm that it accurately states past and present conditions.

<b>DATE</b>	<b>PATIENT SIGNATURE</b>	<b>CHANGES TO HEALTH HISTORY</b>	<b>STUDENT INITIALS</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

# Medication List

Dental Record Number _____
Patient Name (Last, First, MI) _____
Date of Birth(MM/DD/YYYY) _____

Patient to fill out			For use by dentist		
			Update section (enter date of change & the new dose of medication. If discontinued, enter D/C)		
Medication & Dose	Condition prescribed for	MM/YYYY started	Date/Change	Date/Change	Date/Change