Medical and Dental History Evaluation

School of Dental Medicine
UNIVERSITY OF COLORADO ANSCHUTZ MEDICAL CAMPUS
DENTAL. INTEGRATED FOR HEALTH.

Patient Name_____Date of Birth:_____

Our CU Dental team respects and acknowledges the identities of the patients in our care. We ask questions about pronouns, gender identity and sexual orientation to help inform our providers and to provide you with the best care.

Height (inches):_____ Weight (lbs):_____ Sex: ☐ Male ☐ Female ☐ Intersex Pronouns:_____

Gender Identity: ☐ Man ☐ Women ☐ Nonbinary ☐ Gender Nonconforming ☐ Gender Fluid ☐ Transgender ☐ Agender ☐ Other:_____

Sexual Orientation:☐ Heterosexual/Straight☐ Gay☐ Lesbian☐ Bisexual☐ Asexual☐ Pansexual☐ Queer☐ Other:_____☐ Decline to Answer

Medical History

Does the patient have any of the following diseases or problems (active tuberculosis, persistent cough, cough producing blood, exposed to tuberculosis)? ☐ YES ☐ NO

If yes, specify and notify someone at the reception desk:

_____

_____

GENERAL MEDICAL INFORMATION:

Does the patient now, or has the patient in the past year, been under the care of a physician? ☐ YES ☐ NO

If so, please provide the name, location, phone number of the physician and date of last exam.

_____

_____

Has the patient had any serious illness, operation, or been hospitalized in the past 5 years? ☐ YES ☐ NO

If yes, specify: _____

Has the patient had an organ transplant? ☐ YES ☐ NO

If yes, specify: _____

Has the patient had open heart surgery? ☐ YES ☐ NO

If yes, specify: _____

Has the patient had an orthopedic total joint replacement (e.g. hip, knee, elbow, or finger)? ☐ YES ☐ NO

If yes, specify: _____

Has the patient ever had any radiation therapy or chemotherapy for a growth, tumor or other condition?

☐ YES ☐ NO

If yes, specify: _____

Has the patient (within the past 2 years) or is the patient now taking steroids (e.g. Cortisone)? ☐ YES ☐ NO

If yes, specify: _____

Has the patient, is the patient taking or is the patient scheduled to begin taking **oral** bisphosphonates or antiresorptive (Alendronate (Fosamax, Fosamax Plus D), Etidronate (Didronel), Ibandronate (Boniva), Risedronate (Actonel), or Tiludronate (Skelid), Denosumab))?

☐ YES ☐ NO

Has the patient, is the patient or is the patient scheduled to begin taking **intravenous** bisphosphonates (Clodronate (Bonefos), Pamidronate (Aredia) or Zoledronic Acid (Reclast, Zometa))? ☐ YES ☐ NO

Are there any health conditions that require the patient to take medication prior to dental treatment?

☐ YES ☐ NO

If yes, specify: _____

Have there been any changes in the patients' general health within the past year? ☐ YES ☐ NO

If yes, specify: _____

Child only:

Are the child's immunizations up to date? ☐ YES ☐ NO

FALL RISK ASSESSMENT:

Has the patient fallen or almost fell in the past three months? ☐ YES ☐ NO

Does the patient have a fear of falling? ☐ YES ☐ NO

Does the patient have difficulty ambulating (walking or moving around?) ☐ YES ☐ NO

Does the patient use an assistive device such as a cane, Walker, wheelchair, crutches or artificial limb? ☐ YES ☐ NO

If yes to any of the above, please specify:

_____

_____

Does the patient have a vision or hearing impairment? ☐ YES ☐ NO

TOBACCO USE:

Does the patient use or has the patient used tobacco (smoking, snuff, chew, bidis, or vaping)? ☐ YES ☐ NO

If yes, specify: _____

ALCOHOL USE:

Does the patient drink alcoholic beverages? ☐ YES ☐ NO

DRUG USE:

Does the patient use prescription or street drugs or other substances, for recreational purposes? ☐ YES ☐ NO

If yes, specify: _____

FEMALES ONLY:

Is the patient pregnant? ☐ YES ☐ NO

Is the patient nursing? ☐ YES ☐ NO

Is the patient taking birth control pills, fertility drugs, or hormonal replacement? ☐ YES ☐ NO

If yes, specify:

_____

Child only:

Has menstruation begun? ☐ YES ☐ NO

How long ago did menstruation begin?

☐0-6 months ☐6-12 months ☐1-2 years ☐More than 2 years

MEDICATIONS:

Is the patient taking, has the patient recently (within the last month) taken, or is the patient supposed to be taking any medications (prescription, over the counter, diet supplements, vitamins, natural or herbal)? ☐ YES ☐ NO

If yes, please list or attach list of all medication(s), dosage and frequency:

_____

_____

_____

_____

ALLERGIES:

Does the patient have any allergies (medications, food, other)? ☐YES ☐NO

If yes, specify: _____

MEDICAL CONDITIONS:

Does the patient have or has had any of the following diseases, problems, or symptoms?

Heart/Blood Pressure problem ☐ YES ☐ NO
Respiratory/Lung problem (including sleep apnea) ☐ YES ☐ NO
Diabetes/Endocrine disorder ☐ YES ☐ NO
If diabetic, latest HbA1c value: _____
Kidney/Urinary disorder ☐ YES ☐ NO
Cancer or Tumors ☐ YES ☐ NO
Neurologic/Nerve problem ☐ YES ☐ NO
Psychiatric disease/Mental Health disorder ☐ YES ☐ NO
Blood/Hematologic disorder ☐ YES ☐ NO
Stomach/Intestine/Liver disorder ☐ YES ☐ NO
Muscle/Bone/Connective Tissue disorder ☐ YES ☐ NO
Infectious disease ☐ YES ☐ NO
Genetic Disorder/Chromosomal Abnormalities/ Other Developmental Problems ☐ YES ☐ NO
Head/Eye/Ear/Nose/Throat problem ☐ YES ☐ NO
Dermatologic/Skin problem ☐ YES ☐ NO
Eating disorder ☐ YES ☐ NO

Does the patient have any other problem, disease or condition not listed above?

If yes, specify:_____

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Dental History

What is the reason for the patient's dental visit today? _____

_____

PRIMARY DENTIST INFORMATION

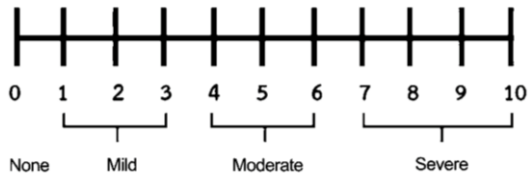
Practice Name: _____ Phone Number: _____
Dentist Name: _____

Address: _____

DENTAL PROBLEMS (SIGNS/SYMPTOMS):

Is the patient currently experiencing dental pain or discomfort? ◯ YES ◯ NO

If "Yes" to the previous question please mark on the pain schedule how much pain the patient is in.



Are the patients' teeth sensitive to cold, hot, sweets or pressure? ☐ YES ☐ NO

If yes, specify: _____

Does the patient have problems with eating (trouble chewing, trouble swallowing, vomiting, etc)? ☐ YES ☐ NO

If yes, specify: _____

Does the patient have swelling in or around the mouth, face or neck? ☐ YES ☐ NO

If yes, specify: _____

Does the patient have loose teeth? ☐ YES ☐ NO

If yes, specify: _____

Does the patient have headaches, earaches, or neck pains? ☐ YES ☐ NO

If yes, specify: _____

Does the patient have any clicking, popping, or discomfort or limited opening in the jaw? ☐ YES ☐ NO

If yes, specify: _____

Does the patient have sores or ulcers in their mouth? ☐ YES ☐ NO

If yes, specify: _____

Has the patient ever had a serious injury to the head or mouth? ☐ YES ☐ NO

If yes, specify: _____

Is the patient unhappy with their smile or appearance of their teeth? ☐ YES ☐ NO

If yes, specify: _____

PAST DENTAL TREATMENT:

Has the patient been to the dentist before? ☐ YES ☐ NO

If yes, how long ago was the last dental visit?

☐ 0-6 Months ☐ 6-12 Months ☐ 1-2 Years ☐ More than 2 years

If yes, how long ago was the last dental exam?

☐ 0-6 Months ☐ 6-12 Months ☐ 1-2 Years ☐ More than 2 years

If yes, how long ago was the last dental x-ray?

☐ 0-6 Months ☐ 6-12 Months ☐ 1-2 Years ☐ More than 2 years

If yes, how long ago was the last dental cleaning?

☐ 0-6 Months ☐ 6-12 Months ☐ 1-2 Years ☐ More than 2 years

Does the patient have a history of significant dental therapy (implants, cosmetic procedures or TMJ surgery)? ☐ YES ☐ NO

If yes, specify: _____

Has the patient had any periodontal (gum) treatments? ☐ YES ☐ NO

If yes, specify: _____

Does the patient have bridges or wear dentures or partials? ☐ YES ☐ NO

If yes, specify: _____

Has the patient ever had root canal treatment? ☐ YES ☐ NO

If yes, specify: _____

Has the patient ever had orthodontic (braces) treatment?
☐ YES ☐ NO

If yes, specify: _____

Has the patient had a local anesthetic (Novocaine) for dental purposes? ☐ YES ☐ NO

Has the patient had any problems associated with previous dental treatment? ☐ YES ☐ NO

If yes, specify: _____

DENTAL DISEASE PREVENTION (ORAL HYGIENE/DIET):

How often does the patient brush their teeth?

_____

How often does the patient floss their teeth?

_____

Do the patients' gums bleed when brushing or flossing?
☐ YES ☐ NO

ORAL HABITS:

Does the patient clench, brux, or grind teeth?

☐ YES ☐ NO

If yes, specify: _____

Child only:

Does someone assist the child with brushing and cleaning their teeth? ☐ YES ☐ NO

Does the child snack between meals more than 3 times daily and/or have a diet high in carbohydrates (sugar/starch) (Specify):

☐ Frequent Snacking ☐ Diet High in Carbohydrates

Does the child have adequate fluoride exposure (lives or goes to school in a fluoridated community, uses fluoride toothpaste, uses fluoride mouth rinse, has had a topical fluoride varnish treatment within the last 6 months)? (Specify):

☐ Lives or goes to school in a fluoridated community

☐ Fluoride toothpaste used at least once per day

☐ Fluoride mouth rinse used daily

☐ Topical fluoride treatment within the last 6 months

☐ Fluoride varnish treatment within the last 6months

Does the child suck their thumb, finger and/or pacifier?

☐ Thumb ☐ Finger ☐ Pacifier