

Medical and Dental History Evaluation

Patient Name _____ Date of Birth: _____

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

Gender Identity: Man Woman Nonbinary Gender Nonconforming Gender Fluid Transgender Agender Other: _____

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

Medical History

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

If yes, specify: _____

GENERAL MEDICAL INFORMATION:

Are you now, or have you been in the past year, under the care of a physician? YES NO

If so, please provide the name, location and phone number of your physician.

Have you had any serious illness, operation, or been hospitalized in the past 5 years? YES NO

If yes, specify: _____

Have you had an organ transplant? YES NO

If yes, specify: _____

Have you had open heart surgery? YES NO

If yes, specify: _____

Have you had an orthopedic total joint (e.g. hip, knee, elbow, finger) replacement? YES NO

If yes, specify: _____

Have you ever had any radiation therapy or chemotherapy for a growth, tumor or other condition? YES NO

If yes, specify: _____

Have you taken (within past 2 years) or are you now taking steroids (e.g. Cortisone)? YES NO

If yes, specify: _____

Have you taken, are you taking or are you scheduled to begin taking **oral** bisphosphonates (Alendronate (Fosamax, Fosamax Plus D), Etidronate (Didronel), Ibandronate (Boniva), Risedronate (Actonel), or Tiludronate (Skelid))? YES NO

Have you taken, are you taking or are you scheduled to begin taking **intravenous** bisphosphonates (Clodronate (Bonefos), Pamidronate (Aredia) or Zoledronic Acid (Reclast, Zometa))? YES NO

TOBACCO USE:

Do you use or have you used tobacco (smoking, snuff, chew, bidis)? YES NO

If yes, specify: _____

ALCOHOL USE:

Do you drink alcoholic beverages? YES NO

FALL RISK ASSESSMENT:

Have you fallen or almost fell in the past three months? YES NO

Do you have a fear of falling? YES NO

Do you have difficulty walking or moving around? YES NO

Do you 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: _____

DRUG USE:

Do you use prescription or street drugs or other substances for recreational purposes? YES NO

If yes, specify: _____

FEMALES ONLY:

Are you pregnant? YES NO

Are you nursing? YES NO

Are you taking birth control pills, fertility drugs, hormonal replacement? YES NO

If yes, specify: _____

ALLERGIES:

Do you have any allergies (medications, food, other?) YES NO

If yes, specify: _____

MEDICAL CONDITIONS:

Do you have or have you 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

• 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

• Head/Eye/Ear/Nose/Throat problem YES NO

• Dermatologic/Skin problem YES NO

• Eating disorder YES NO

Do you have any other problem, disease or condition not listed above? YES NO

If yes, specify: _____

Dental History

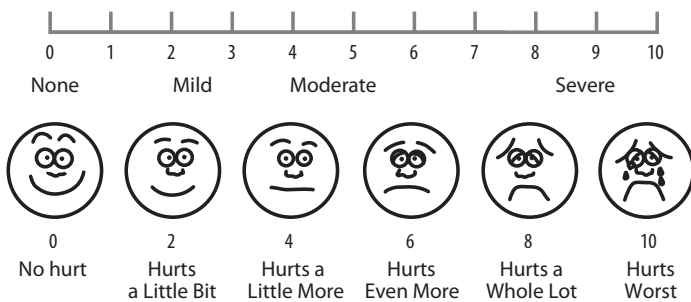
What is the reason for your dental visit today? _____

DENTAL PROBLEMS (SIGNS/SYMPTOMS):

Are you currently experiencing dental pain or discomfort? YES NO

If "Yes" to the previous question please mark on the pain schedule how much pain you have.

PAIN RATING SCALE



Are your teeth sensitive to cold, hot, sweets or pressure? YES NO
If yes, specify: _____

Do you have problems with eating (trouble chewing, trouble swallowing, vomiting, etc)? YES NO
If yes, specify: _____

Do you have swelling in or around your mouth, face or neck? YES NO
If yes, specify: _____

Do you have loose teeth? YES NO
If yes, specify: _____

Do you have headaches, earaches or neck pains? YES NO
If yes, specify: _____

Do you have any clicking, popping or discomfort or limited opening in the jaw? YES NO
If yes, specify: _____

Do you have sores or ulcers in your mouth? YES NO
If yes, specify: _____

Have you ever had a serious injury to your head or mouth? YES NO
If yes, specify: _____

Are you unhappy with your smile or the appearance of your teeth? YES NO

PAST DENTAL TREATMENT:

Have you been to the dentist before? YES NO

If so, what is the name, location and phone number of your dentist? _____

Do you have a history of significant dental therapy (implants, cosmetic procedures or TMJ surgery)? YES NO

If yes, specify: _____

Have you had any periodontal (gum) treatments? YES NO

If yes, specify: _____

Do you have bridges or wear dentures or partials? YES NO

If yes, specify: _____

Have you ever had root canal treatment? YES NO
If yes, specify: _____

Have you ever had orthodontic (braces) treatment? YES NO

Have you had a local anesthetic (Novocaine) for dental purposes? YES NO

Have you had any problems associated with previous dental treatment? YES NO
If yes, specify: _____

DENTAL DISEASE PREVENTION (ORAL HYGIENE/DIET):

How often do you brush your teeth? _____

How often do you floss your teeth? _____

Do your gums bleed when you brush or floss? YES NO

ORAL HABITS:

Do you clench, brux, or grind your teeth? YES NO
If yes, specify: _____

MEDICATIONS:

Are you taking, have you recently (within the last month) taken, or are you supposed to be taking any medications (prescription, over the counter, diet supplements, vitamins, natural or herbal)? YES NO

If yes, please list all medications: _____

