

Name: \_\_\_\_\_  
Last First Middle

Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Height in Feet: \_\_\_\_\_ Inches: \_\_\_\_\_ Weight (lbs): \_\_\_\_\_

Who referred you to us? \_\_\_\_\_

**PLEASE CIRCLE YOUR RESPONSES (YES, NO, DK (DON'T KNOW)) TO INDICATE IF YOU HAVE, HAVE NOT OR DO NOT KNOW IF YOU HAVE HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS.**

**GENERAL MEDICAL INFORMATION:**

**YES NO DK** Are you, or have you been in the past year, seen by a primary care provider (PCP)?  
If yes, please list name and location: \_\_\_\_\_

**YES NO DK** Are you seen by any medical specialists? If yes, please list name(s) and location(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**YES NO DK** Do you have active tuberculosis or have you been exposed to anyone with tuberculosis? Specify: \_\_\_\_\_

**YES NO DK** Have you had heart surgery? If yes, please specify: **STENTS VALVES BYPASS (CABG)** Other: \_\_\_\_\_  
Date(s) and any complications: \_\_\_\_\_

**YES NO DK** Have you had an organ/bone marrow transplant? Specify: **HEART LUNG KIDNEY LIVER BMT** Other: \_\_\_\_\_  
Date(s) and any complications: \_\_\_\_\_

**YES NO DK** Have you had an orthopedic total joint replacement? If yes, please specify: **HIP KNEE OTHER:** \_\_\_\_\_  
Date(s) and any complications: \_\_\_\_\_

**YES NO DK** Do you now or have you ever had cancer? If yes, how was it treated?  
 Surgery: diagnosis, site, when: \_\_\_\_\_  
 Radiation: diagnosis, site, when: \_\_\_\_\_  
 Chemotherapy: diagnosis, site, when: \_\_\_\_\_  
 Medication to prevent or treat bone complications: If yes, please specify:  
 Xgeva (Denosumab)  Aredia (Pamidronate)  Zometa (Zoledronic Acid) Other: \_\_\_\_\_  
Length of time taken: \_\_\_\_\_

**YES NO DK** Have you had any serious illness, surgery, or been hospitalized? If yes, how long ago?  
 **0-12 MONTHS** Specify: \_\_\_\_\_  
 **1-5 YEARS** Specify: \_\_\_\_\_  
 **> 5 YEARS** Specify: \_\_\_\_\_

**YES NO DK** Do you use or have you used tobacco products? If yes, please specify type:  
**CIGARETTES E-CIGARETTES CIGARS PIPES HOOKAH SNUFF CHEW OTHER:** \_\_\_\_\_  
 **PAST:** When did you stop: \_\_\_\_\_ How many years of use: \_\_\_\_\_  
 **CURRENT:**  > 10 per day  < 10 per day  Occasionally For how many years: \_\_\_\_\_  
How interested are you in stopping? **VERY SOMEWHAT NOT INTERESTED**

**YES NO DK** Do you drink alcoholic beverages? If yes, daily? **YES NO DK** How many drinks per week? \_\_\_\_\_

**YES NO DK** Do you use or have you used prescription, street drugs or other substances for recreational purposes? (Specify):  
 **PAST**  **CURRENT** Are you drug dependent? **YES NO DK**  
(Specify): **COCAINE ECSTASY HEROIN MARIJUANA METH OPIOIDS** Other: \_\_\_\_\_

**MEDICAL CONDITIONS: Do you have (or have you had) any of the following diseases, problems, or symptoms?**

**YES NO DK Eye/Ear/Nose/Throat problem**

*If yes, please specify:*

- Vision problems
  - Cataracts
  - Glaucoma
    - Narrow angle
    - Open angle
  - Macular degeneration
- Hearing impairment
- Hay fever/seasonal (allergic rhinitis)
- Other: \_\_\_\_\_

**YES NO DK Heart/Blood Pressure problem**

*If yes, please specify:*

- High blood pressure
- High cholesterol/high triglycerides
- Infective endocarditis
- Congenital heart defect/disease
- Angina (chest pain)
- Heart attack
- Heart failure
- Coronary heart disease
- Arrhythmia (irregular heart beat)
- Pacemaker/Implanted defibrillator
- Other: \_\_\_\_\_

**YES NO DK Breathing/Lung problem**

*If yes, please specify:*

- Asthma
- Emphysema/COPD
- Sinusitis
- Bronchitis
- Pneumonia
- Obstructive sleep apnea
  - Use CPAP/BiPAP
  - Surgical correction
  - Oral appliance
- Other: \_\_\_\_\_

**YES NO DK Stomach/Intestine/Liver disorder**

*If yes, please specify:*

- Acid reflux (GERD)
- Ulcers
- Crohn's disease
- IBS (Irritable Bowel Syndrome)
- Ulcerative colitis
- Celiac disease
- Hepatitis
  - A    B/D    C
- Cirrhosis
- Other: \_\_\_\_\_

**YES NO DK Eating disorder**

*If yes, please specify:*

- Bulimia
- Anorexia
- Other: \_\_\_\_\_

**YES NO DK Kidney/Urinary disorder**

*If yes, please specify:*

- Chronic kidney disease
- Renal failure/Dialysis
- Bladder problems
- Urinary incontinence
- BPH (Benign Prostate Hypertrophy)
- Other: \_\_\_\_\_

**YES NO DK Muscle/Bone disorder**

*If yes, please specify:*

- Osteoarthritis
- Osteoporosis
- Gout
- Temporomandibular joint disorder
- Fibromyalgia
- Other: \_\_\_\_\_

**YES NO DK Skin problem**

*If yes, please specify:*

**YES NO DK Neurologic/Nerve problem**

*If yes, please specify:*

- Stroke
- TIA (Transient Ischemic Attack)
- Seizures/Epilepsy
- Multiple sclerosis
- Parkinson's disease
- Neuropathies (tingling, numbness)
- Dementia/Alzheimer's (memory loss)
- Autism
- Headache
- Other: \_\_\_\_\_

**YES NO DK Mental Health disorder**

*If yes, please specify:*

- Bipolar disorder
- Depression
- Schizophrenia
- PTSD (Post Traumatic Stress Disorder)
- ADD/ADHD (Attention Deficit Disorder)
- Generalized anxiety disorder
- Panic attacks
- Other: \_\_\_\_\_

**YES NO DK Diabetes/Endocrine disorder**

*If yes, please specify:*

- Diabetes
  - Type 1    Type 2
- Thyroid problems
  - Hypothyroidism (low)
  - Hyperthyroidism (high)
- Other: \_\_\_\_\_

**YES NO DK Blood/Hematologic disorder**

*If yes, please specify:*

- Anemia
- Sickle cell disease/trait
- Leukemia
- Lymphoma
- Multiple myeloma
- Bleeding disorders
  - Hemophilia
  - Von Willebrand Disease
  - Thrombocytopenia (low platelets)
- Other: \_\_\_\_\_

**YES NO DK Immune System disorder**

*If yes, please specify:*

- Lupus erythematosus
- Rheumatoid arthritis
- Sjögren's syndrome
- Other: \_\_\_\_\_

**YES NO DK Infectious disease**

*If yes, please specify:*

- HIV/AIDS
- STD (Sexually Transmitted Disease)
- Cold sores
- Other: \_\_\_\_\_

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

*If yes, please specify:*

**ANESTHETIC HISTORY**

**YES NO DK Anesthesia problems**

- Difficult intubation
- Malignant hyperthermia
- Prolonged/difficulty waking up
- Post-operative nausea and vomiting
- Other (Specify): \_\_\_\_\_



## ADULT DENTAL HISTORY

### REASON FOR VISIT:

What is the reason for your dental visit today? **EXAMINATION EMERGENCY CONSULTATION PROCEDURE**

Specify: \_\_\_\_\_

### PAST DENTAL TREATMENT:

- YES NO DK** Have you been to the dentist before?  
If yes, how long ago was your last dental exam? **0-6 MONTHS 6-12 MONTHS 1-2 YEARS > 2 YEARS**  
If yes, how long ago was your last dental x-ray? **0-6 MONTHS 6-12 MONTHS 1-2 YEARS > 2 YEARS**  
If yes, how long ago was your last dental cleaning? **0-6 MONTHS 6-12 MONTHS 1-2 YEARS > 2 YEARS**
- YES NO DK** Do you have a history of tooth extraction or oral surgery?  
(Specify): **EXTRACTIONS IMPLANTS JAW SURGERY TMJ SURGERY TRAUMA**
- YES NO DK** Have you had any periodontal (gum) treatments? (Specify): **DEEP CLEANING SURGERY**
- YES NO DK** Do you have bridges or wear dentures or partials? (Specify): **BRIDGES DENTURES PARTIALS**
- YES NO DK** Have you ever had root canal treatment?
- YES NO DK** Have you ever had orthodontic (braces) treatment?
- YES NO DK** Have you had a local anesthetic (Lidocaine) for dental purposes?  
**YES NO DK** If yes, have you experienced any problems? (needle anxiety, hard to get numb, etc.)
- YES NO DK** Have you had any problems associated with previous dental treatment?
- YES NO DK** Has fear ever prevented you from seeking dental care?

### DENTAL PROBLEMS (SIGNS/SYMPTOMS):

- YES NO DK** Are you currently experiencing dental pain or discomfort?  
If yes, is it causing headaches, earaches or neck pains? (Specify): **HEADACHES EARACHES NECK PAINS**
- YES NO DK** Are your teeth sensitive to cold, hot, sweets or pressure? (Specify): **COLD HOT SWEETS PRESSURE**
- YES NO DK** Do you have problems with eating? (Specify): **TROUBLE CHEWING SWALLOWING VOMITING OTHER**
- YES NO DK** Do you have swelling in or around your mouth, face or neck? (Specify): **MOUTH FACE NECK**
- YES NO DK** Do you have loose teeth?
- YES NO DK** Do you have any clicking, popping, discomfort, or limited opening in the jaw?  
(Specify): **CLICKING POPPING DISCOMFORT LIMITED OPENING**
- YES NO DK** Do you have or have you had sores or ulcers in your mouth? If yes, location: \_\_\_\_\_
- YES NO DK** Have you ever injured your face, jaws or teeth?
- YES NO DK** Are you unhappy with your smile or the appearance of your teeth?
- YES NO DK** Do you have a bad taste or bad breath? (Specify): **BAD TASTE BAD BREATH**
- YES NO DK** Do you experience dry mouth?

### DENTAL DISEASE PREVENTION (ORAL HYGIENE):

- How often and when do you brush your teeth? **NEVER SOMETIMES 1x/WEEK 1x/DAY 2x/DAY > 2x/DAY AM PM**
- How often do you floss your teeth? **NEVER SOMETIMES 1x/WEEK 1x/DAY > 1x/DAY**
- Do your gums bleed when you brush or floss? **NEVER SOMETIMES ALWAYS**

### ORAL HABITS:

- YES NO DK** Do you clench, brux, or grind your teeth? (Specify): **CLENCH BRUX/GRIND BOTH**
- YES NO DK** Do you chew on ice or potentially damaging objects (pencils, bottle caps, etc)? (Specify): **ICE OBJECTS BOTH**