The University of Iowa College of Dentistry requests this information for the purpose of providing a complete and comprehensive evaluation of your dental needs. No persons outside the University will be provided this information unless properly authorized by you or required by law. Failure to provide the requested information will limit our ability to assess your needs and may result in the College being unable to accept you as a patient. Thank you.

**Vitals:**

Height: Feet __________ Inches: ___________ Weight (Lbs.) ______________

**Medical History**

Circle 1. Do you have (or have you ever had) any of the following?

- Yes No a. allergic reaction to drugs or latex (Circle all that apply)
  - Latex
  - Penicillin
  - Sulfur
  - Aspirin
  - Codeine
  - Local Anesthetics
  - Metal
  - Other

- Yes No b. heart attack or heart disease
- Yes No c. stroke
- Yes No d. high blood pressure
- Yes No e. congestive heart failure
- Yes No f. angina (chest pains)
- Yes No g. irregular heart beat
- Yes No h. artificial heart valve
- Yes No i. rheumatic fever, rheumatic heart disease
- Yes No j. bacterial endocarditis (SBE)
- Yes No k. congenital heart disease
- Yes No l. heart murmur or mitral valve prolapse
- Yes No m. Immunosuppressive condition (Circle all that apply)
  - Steroid Therapy (e.g. prednisone)
  - Radiation Therapy
  - Chemotherapy
  - SLE (Lupus)
  - Rheumatoid Arthritis
  - HIV
  - Organ Transplant
  - Spleen removed
  - Other

- Yes No n. artificial joint(s) (Circle all that apply)
  - Hip
  - Knee
  - Ankle
  - Shoulder
  - Other
  
  Date(s) placed:
  - Yes No o. other artificial implants or devices
  - Yes No p. bleeding problem, anemia, other blood disease
  - Yes No q. diabetes
  - Yes No r. thyroid disease
  - Yes No s. nervous system disease or seizures
  - Yes No t. stomach or intestinal disease
  - Yes No u. kidney disease
  - Yes No v. hepatitis (A, B, C, D or E)
  - Yes No w. other liver disease
  - Yes No x. arthritis (osteo or rheumatoid)
  - Yes No y. other muscle or joint disease
  - Yes No z. asthma
  - Yes No aa. tuberculosis
  - Yes No bb. other lung disease
  - Yes No cc. mental health condition - specify: ____________________________
  - Yes No dd. physical or mental disabilities that may require special care
  - Yes No ee. Do you have or have you ever been treated for cancer?
  - Yes No ff. Are you or could you be pregnant?
  - Yes No gg. Are you nursing?
  - Yes No jj. Do you have difficulty hearing?
2. Do you have any disease, condition, or problem not listed here?  
Describe:

3. Have you ever been hospitalized or had surgery?  
Describe:

4. Do you have any undiagnosed symptoms?  
Describe:

5. Are you, or have you ever been addicted to a chemical substance?  
(examples: alcohol, prescription drugs, heroin, meth, cocaine, other)

6. Do you regularly take herbal medicines or dietary supplements?  
Specifically, do you take (circle all that apply):

Echinacea  Garlic  Ginger  Kava  Valerian  Feverfew
Gingko  Ginseng  St. John’s Wort  Vitamin E  Other: _____________

7. Have you undergone current or past osteoporosis therapy?  
(Examples are: Fosamax, Actonel, Boniva pill form)

8. Have you undergone current or past bisphosphonate therapy?  
(Examples: intravenous Aredia, Zometa)

9. Have you received an influenza immunization during the flu season  
(September through February)

Tobacco Use

1. Have you ever smoked?  
If yes to #1 please check the appropriate box

☐ Former Smoker  ☐ Smokes Occasionally  ☐ Smokes Rarely  ☐ Smokes < 10/day  ☐ Smokes > 10/day

2. Forms of tobacco used: ___________________________________________________

3. If yes to #1 – Are you interested in quitting?  ☐ No  ☐ Somewhat  ☐ Yes

Physician List  (please list your family physician and any medical specialists you see at least once a year):

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>City</th>
<th>Phone#</th>
<th>Name of Specialty</th>
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Dental History

Chief Complaint: (Why are you seeking dental care?) __________________________

1. Do you have regular dental check-ups?

2. When was your last dental exam? ____________

3. Have you had any trouble associated with previous dental treatment?  
If so, please explain: ________________________________

4. Have you noticed any lumps or sores in your mouth?

5. Do your gums bleed when you brush your teeth?

6. Have you ever injured your face, jaws or teeth?

7. Do you suffer from pain in the mouth, face, eyes, neck or throat?

8. Are you unhappy with the appearance of your teeth?

9. Has fear ever prevented you from seeking dental treatment?

10. Are you allergic to any metals or dental materials?

11. Circle the types of dental treatment you have experienced:

Orthodontics (braces)  Dentures  Root canal treatment  Implants
Oral Surgery  Periodontal (gum) treatment  TMJ treatment  Fillings
Crowns  Bridges  Veneers  Bleaching  Other: _____________