Medical and Dental History Evaluation

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

Patient Name_____

Date of Birth_____Height (inches): _____ Weight (lbs):_____

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: _____

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Dental History

What is the reason for your dental visit today? _____

_____

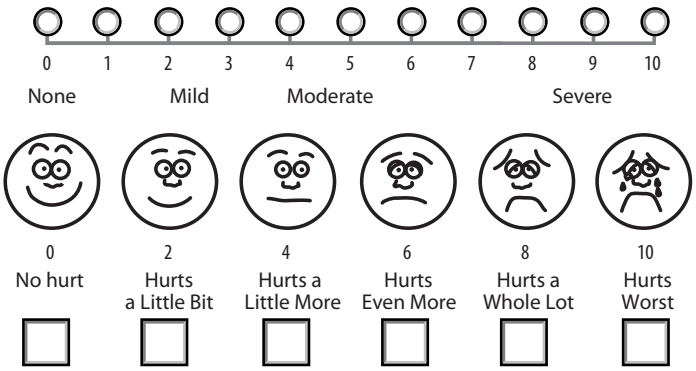
_____

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: _____

_____

_____

_____

_____