UAB DENTISTRY leading oral health care

Health History

STUDENTS/DENTISTS: Enter this information into Salud during the patient interview and store this form in the jacket of the paper chart.

Is this your first visit? Yes _____ No _____

Today's Date:

Patient Chart Number:

Dental Information

Please mark (X) your responses to the following questions. Check DK if you Don't Know the answer to the question.

What is the reason for your dental visit today? ____________________

How did you hear about our clinic? Dental Referral _____ Family/Friends _____ UAB Employee _____ Internet _____ Print _____ Other_____

How often do you see a dentist? ______________ When was your last dental visit? _________ What was done at the visit? __________________

	Yes	No	DK
Do you wear dentures or partials?....................................	☐	☐	☐
Are you currently experiencing dental pain or discomfort?..	☐	☐	☐
Do your gums bleed when you brush or floss?....................	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or biting?........	☐	☐	☐
Does food or floss catch between your teeth?....................	☐	☐	☐
Is your mouth excessively dry?...	☐	☐	☐
Have you had periodontal (gum) surgery?..........................	☐	☐	☐
Have you ever had orthodontic (braces) treatment?..........	☐	☐	☐
Have you had problems associated with previous dental treatment?..	☐	☐	☐
Are you apprehensive about dental care?...........................	☐	☐	☐
Do you have frequent sore throats?....................................	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pain?..............	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?..	☐	☐	☐
Do you clench or grind your teeth?................	☐	☐	☐
Do you get sores or ulcers in your mouth?......	☐	☐	☐
Have your ever had a serious injury to your face, jaw, teeth, mouth?...............................	☐	☐	☐
Oral habits			
Thumb/finger habit?......................................	☐	☐	☐
Lip/nail biting habit?.....................................	☐	☐	☐

How do you feel about your smile? ____________________________

____

Medical Information

Please mark (X) your responses to the following questions. Check DK if you Don't Know the answer to the question.

	Yes	No	DK
1) Are you in good health?	☐	☐	☐

If no or don't know, please explain?

	Yes	No	DK
2) Have there been any changes in your general health within the past year?..	☐	☐	☐

If yes, please explain

	Yes	No	DK
3) Are you now under the care of a physician?.................	☐	☐	☐

If yes, what is/are the conditions(s) being treated?

Physician or Clinic Name: Phone: ( )

	Yes	No	DK
4) Have you had any serious illness, operation, organ transplant or been hospitalized in the past 5 years?...........................	☐	☐	☐

If yes, what was the illness or problem?

	Yes	No	DK
5) Have you had cancer, tumor, malignancy?..................	☐	☐	☐

If yes, type, when, treatment?

	Yes	No	DK
6) Are you taking or have you recently taken any medicine(s) including non-prescription medicine?..................................	☐	☐	☐

*If yes, **please list all**, including prescribed, over-the-counter, vitamins natural or herbal preparations and/or diet supplements:*

Name	Dosage	Frequency

MEDICATION(S) CONTINUED*....prescribed, over-the-counter, vitamins natural or herbal preparations and/or diet supplements:*

Name	Dosage	Frequency

	Yes	No	DK
7) Do you drink alcoholic beverages?...........	☐	☐	☐

If yes, how much alcohol did you drink in the last 24 hours? _________

If yes, how much do you typically drink in a week? ________________

	Yes	No	DK
Are you alcohol dependent?...........................	☐	☐	☐
If yes, are you receiving treatment?...............	☐	☐	☐

	Yes	No	DK
8) Do you use drugs or other substances for recreational purposes?.................................	☐	☐	☐

Frequency or use (daily, weekly, etc): __________________________

	Yes	No	DK
Are you drug dependent?............................	☐	☐	☐

Number of years of recreational drug use? __________________

	Yes	No	DK
If yes, are you receiving treatment?...............	☐	☐	☐

	Yes	No	DK
9) Do you smoke, use smokeless tobacco or electronic cigarettes?..	☐	☐	☐

If yes, type, how much/often, packs per day? ________________

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If yes, how interested are you in stopping?

(Circle one) VERY / SOMEWHAT / NOT INTERESTED

Medical Information

Please mark (X) your responses to the following questions. Check DK if you Don't Know the answer to the question.

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10) Allergies: Are you allergic to or have you had a reaction to?
To all **yes** responses, specify type of reaction.

	Yes	No	DK
Latex ____	□	□	□
Local anesthetics __________________________________	□	□	□
General anesthetic _________________________________	□	□	□
Aspirin ____	□	□	□
Penicillin or other antibiotics ________________________	□	□	□
Barbiturates, sedatives, or sleeping pills _______________	□	□	□
Sulfa drugs _______________________________________	□	□	□

Allergies (contd)

	Yes	No	DK
Codeine or other narcotics _____________	□	□	□
Iodine ______________________________	□	□	□
Seasonal ____________________________	□	□	□
Animals _____________________________	□	□	□
Food(s) specify ______________________	□	□	□
Metal(s) specify______________________	□	□	□
Other specify ________________________	□	□	□

11) Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?.................	□	□	□

If yes, what antibiotic and dose? ____
Name of physician making recommendation ______________________________
Phone number ( )

WOMEN ONLY

	Yes	No	DK
Are you or could you be pregnant?................	□	□	□
Number of weeks: ____________			
Nursing?..	□	□	□
Taking birth control pills or hormonal replacement?..	□	□	□

Please mark (x) your response(s) to indicate if you have or have not had any of the following diseases or problems.

CARDIOVASCULAR	Y	N	DK	If yes, please specify
Hypertension				How long
Blood thinner				Type
Congestive heart failure				When
Rheumatic heart disease				When
Angina or chest pain				Type
Myocardial infarction (heart attack)				When
Heart surgery				When
Coronary bypass surgery				Date
Stents				Date
Infective endocarditis				When
Congenital heart defect				Surgery
Prosthetic heart valve				When
Heart transplant				When
Pacemaker/defibrillator				When
Arrhythmias				
Aneurysm				
Shortness of breath				
Swollen ankles				
Other				Specify
HEMATOLOGIC	**Y**	**N**	**DK**	**If yes, please specify**
Blood transfusion				When
Anemia				
Hemophilia				
Leukemia				When
Sickle cell disease				Type
Bleeding tendencies				
Clotting disorders/hypercoagulable state				
Other				Specify
NEUROLOGIC	**Y**	**N**	**DK**	**If yes, please specify**
Glaucoma				When
Hearing loss				
Severe headaches				
Fainting spells				When
Stroke/CVA				Type

NEUROLOGIC...CONTINUED	Y	N	DK	If yes, please specify
Stroke/CVA				Type
Neuralgia				
Shingles				
Seizures/epilepsy				Last seizure?
Psychiatric treatment				
Paralysis				
Convulsions				
GASTROINTESTINAL/LIVER	**Y**	**N**	**DK**	**If yes, please specify**
Stomach ulcers				
Gastritis/colitis				
GERD/reflux				
Hepatitis				Type
Liver disease				
Jaundice				
Cirrhosis				
Other				Specify
RESPIRATORY				
	Y	**N**	**DK**	**If yes, please specify**
Seasonal allergies				
Sinus trouble				
Asthma				
What is asthma induced by?				
Is inhaler used?				Last used?
Emphysema				O_2 therapy?
Bronchitis				
Chronic obstructive pulmonary disorder (COPD)				
Tuberculosis				
Breathing difficulties				When
Sleep disorders				Cpap?
Other				Specify
IMMUNE SYSTEM	**Y**	**N**	**DK**	**If yes, please specify**
HIV positive				
AIDS				
Sjogren's syndrome				

Neuralgia					Systemic lupus erythematosus				
Shingles					Immunosuppressant drugs				

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Please mark (x) your response(s) to indicate if you have or have not had any of the following diseases or problems.

ENDOCRINE	Y	N	DK	If yes, please specify	If you have any disease, condition, or problem not listed that you think I should know about, please explain below
Diabetes					
Thyroid Disease				Type	
Taking or ever taken steroids				When	
How long?				Last used?	
Other				Specify	
GENITOURINARY	**Y**	**N**	**DK**	**If yes, please specify**	
Kidney problems					
Dialysis				Schedule	
Sexually transmitted disease					
Other				Specify	
MUSCULOSKELETAL	**Y**	**N**	**DK**	**If yes, please specify**	
Arthritis				Type	
Joint replacement			Which joint?		
When? Complications?					
Physician's name			Phone number ( )		
Bone disorder				Type	
Muscle disorder					
Other				Specify	

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian:	**Date:**

FOR COMPLETION BY DENTIST:

Blood pressure ______________________ **Pulse** ______________________

ASA Classification: (Circle one) Type I Type II Type III Type IV

Comments on patient interview concerning health history: ______________________

Significant findings from questionnaire or oral interview: ______________________

Dental management considerations: ______________________

Health History Update: