HCC DENTAL EDUCATION CLINIC
HEALTH HISTORY FORM

MEDICAL HISTORY

Patient's Legal Name: Patient's Preferred First Name:	Patient Date of Birth: Patient Preferred Phone Number:
Patient Home Address:	Emergency Contact Name: Emergency Contact Phone Number:

Special Health History Considerations

1. Primary Care Physician's Name_____ Physician Phone _____
   Have you had any medical care within the past two years?..... ☐Yes ☐No
   Describe_____
2. Have you ever taken prescription medications for weight loss (diet pills)..... ☐Yes ☐No
   If yes, did you take any of the following? ☐Fen-Phen ☐Pondimin ☐Redux ☐Other:_____
   If yes to any of the above, did you have a medical exam for heart issues?..... ☐Yes ☐No
3. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs?..... ☐Yes ☐No
4. Do you currently have any allergic, hypersensitivity, or adverse reaction to any substance or medication? ..... ☐Yes ☐No
   If yes, please specify_____
5. Women: Are you pregnant/think you could be pregnant: ☐Yes: Months_____ ☐No Breast Feeding: ☐Yes ☐No
6. Do you use any birth control prescriptions or devices?..... ☐Yes ☐No
7. Please indicate which of the following health conditions you have had, or presently have. Check yes or no to <u>each</u> item.

AIDS/HIV Positive____☐Yes ☐No
Angina/Chest Pain___☐Yes ☐No
Arthritis/Rheumatism_☐Yes ☐No
Artificial Heart Valve/
Pacemaker_____☐Yes ☐No
Artificial Joints_____☐Yes ☐No
Asthma/COPD_____☐Yes ☐No
Autoimmune Disease_☐Yes ☐No
Back/Spine Issues____☐Yes ☐No
Blood Disorder_____☐Yes ☐No
Bruise Easily_____☐Yes ☐No
Cancer/Tumors_____☐Yes ☐No
Chemo/Radiation____☐Yes ☐No
Chronic Cough_____☐Yes ☐No
Cold Sores_____☐Yes ☐No
CPAP/Sleep Apnea___☐Yes ☐No

Diabetes_____☐Yes ☐No
Type:_____ A1c:_____
Dietary Restrictions_____☐Yes ☐No
Drug/Alcohol Use_____☐Yes ☐No
Eating Disorder_____☐Yes ☐No
Epilepsy/Seizures_____☐Yes ☐No
Eye Conditions/Surgery___☐Yes ☐No
Fainting/Dizzy Spells_____☐Yes ☐No
GERD/Peptic Ulcers/
Acid Reflux_____☐Yes ☐No
Headaches/Migraines____☐Yes ☐No
Hearing Impairment_____☐Yes ☐No
Heart Attack/Stroke_____☐Yes ☐No
Heart Disease/Condition__☐Yes ☐No
Type:_____
Hepatitis A, B, C, D, or E___☐Yes ☐No

High/Low Blood Pressure_☐Yes ☐No
Kidney Disease_____☐Yes ☐No
Liver Disease/Jaundice___☐Yes ☐No
Mental Illness/Anxiety___☐Yes ☐No
Mitral Valve Prolapse____☐Yes ☐No
Nerve Disorder_____☐Yes ☐No
Osteoporosis/Osteopenia_☐Yes ☐No
Seasonal Allergy/Sinusitis_☐Yes ☐No
Shortness of Breath_____☐Yes ☐No
Steroid/Cortisone Use____☐Yes ☐No
Surgical Implants_____☐Yes ☐No
Swelling of Feet/Ankles___☐Yes ☐No
Thyroid Disorder_____☐Yes ☐No
Tuberculosis_____☐Yes ☐No
Vision Impairment_____☐Yes ☐No
Other Health Condition(s):_____

8. List any medications (prescription, non-prescription, and/or supplements you are currently taking:_____
   _____
   _____

The answers to the questions listed above are accurate. I understand this information will be used to determine the dental treatment I receive in this clinic and may be shared with other medical offices only as necessary. I will notify this clinic should any information change.

Patient/Guardian Signature_____ Date_____

Dentist Signature_____ Date_____

DH Student Initials

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DENTAL HISTORY

What is the reason for your visit today?_____

Date of last dental visit?_____ Date of last dental cleaning? _____ Date of last x-rays? _____

What was done at your last dental visit? _____

Name of Dentist of Record_____ Dentist's Phone Number_____

Dentist's Address, State, and Zip Code_____

How often do you have dental cleanings/examinations? _____

How often do you brush your teeth?_____ How often do you floss?_____

Have you ever or are you currently using fluoride products (rinse, toothpaste, etc.)_____ ☐Yes ☐No

What other dental aids do you use (Waterpik, toothpick, etc)?_____

Do you have any dental problems that you would like addressed at today's visit?_____ ☐Yes ☐No

If yes, please describe:_____

Are any of your teeth sensitive to:

Hot or cold?_____ ☐Yes ☐No
Sweets?_____ ☐Yes ☐No
Biting or chewing?_____ ☐Yes ☐No
Have you noticed any mouth odors or a bad taste?_____ ☐Yes ☐No
Do you frequently get cold sores, blisters, or any other oral lesions?_____ ☐Yes ☐No
Have your parents experienced gum disease or tooth loss?_____ ☐Yes ☐No
Have you noticed any loose teeth or a change in your bite?_____ ☐Yes ☐No
Does food tend to become caught in between your teeth?_____ ☐Yes ☐No
If yes, where?_____

Do you:

Clench or grind your teeth while awake or asleep?_____ ☐Yes ☐No
Bite your lips or cheeks regularly?_____ ☐Yes ☐No
Hold foreign objects with your teeth such as pencils, pipe, pins, nails?_____ ☐Yes ☐No
Mouth breathe while awake or asleep?_____ ☐Yes ☐No
Have tired jaws, especially in the morning?_____ ☐Yes ☐No
Snore or have any other sleep disorders?_____ ☐Yes ☐No
Smoke, vape, or chew tobacco or use any other tobacco products?_____ ☐Yes ☐No
Currently or ever had any oral piercings?_____ ☐Yes ☐No

Have you ever had:

Orthodontic treatment such as braces or Invisalign?_____ ☐Yes ☐No
Oral surgery or extractions?_____ ☐Yes ☐No
Periodontal surgery or treatment? _____ ☐Yes ☐No
Your bite adjusted?_____ ☐Yes ☐No
A mouth guard or night guard?_____ ☐Yes ☐No
A serious injury to the mouth or head?_____ ☐Yes ☐No
If yes, please describe, including the cause:_____
_____

Have you ever experienced:

Clicking or popping of the jaw?_____ ☐Yes ☐No
Pain (joint, ear, side of face)?_____ ☐Yes ☐No
Difficulty in opening or closing the mouth?_____ ☐Yes ☐No
Difficulty in chewing on either side of the mouth?_____ ☐Yes ☐No
Headaches, neck aches, or shoulder aches?_____ ☐Yes ☐No
Sore muscles (neck, shoulders)?_____ ☐Yes ☐No
Are you satisfied with your teeth's appearance?_____ ☐Yes ☐No
Would you like to keep all of your teeth your entire life?_____ ☐Yes ☐No
Do you feel nervous about having dental treatment?_____ ☐Yes ☐No
If so, what is your biggest concern?_____
Have you ever had a bad dental experience? ☐Yes ☐No
If yes, please describe: _____

Have you ever been told that you need pre-medication before any dental treatment? ☐Yes ☐No

Is there anything else about having dental treatment that you would like us to know? ☐Yes ☐No

If yes, please describe: _____

_____

PLEASE COMPLETE OTHER SIDE