Community Health Center of Franklin County
Desmond Callan Community Health Center

Dental professionals typically treat the area in and around your mouth. Because your mouth is a part of your whole body, health problems that you have or medications that you may be taking could have important interrelationships with dentistry that you will be receiving. Please answer the following questions accurately to ensure our ability to provide safe care for you.

PATIENT MEDICAL HISTORY

1. Are you in good health?_______________ Yes No
2. Have you had significant changes to your general health in the last year? ____ Yes No
3. Date of last physical exam? ______________
4. Physician's name ________________________________
   Address ______________________________________
   Phone ____
5. Are you now under the care of a physician?_________________________ Yes No
6. Have you ever been hospitalized for any surgical operation or serious illness?____ Yes No
7. Are you taking any medicines, including non-prescription medications, vitamins, or herbs? Yes No
   If yes, please list: _________________________________
   ____
   ____
8. Have you had any abnormal bleeding?___Yes No
10. Have you had a blood transfusion?_____Yes No
11. Have you had a recent weight loss? Yes No
12. Have you ever taken Fen-Phen/Redux?_Yes No
13. Do you use tobacco?________________Yes No
14. Do you or have you used controlled substances?______________________ Yes No
15. Are you wearing contact lenses?_____ Yes No
16. Do you have a persistent cough or throat clearing not associated with a known illness and lasting more than 3 weeks?________________ Yes No
17. Do you have any condition, disease, or problem not listed that you think we should know about?Yes No
    ____

WOMEN ONLY:

Are you pregnant or think you may be pregnant? Yes No
Are you nursing? _______________________ Yes No
Are you taking birth control pills?____________ Yes No

Patient Name: ________________________
Date of Birth: ___________________

ARE YOU ALLERGIC OR HAVE YOU HAD REACTIONS TO:

Local anesthetics_____________________ Yes No
Penicillin or other antibiotics___________ Yes No
Sulfa drugs__________________________ Yes No
Barbiturates, sedatives, or sleeping pills____Yes No
Aspirin______________________________Yes No
Iodine_______________________________ Yes No
Any metals___________________________ Yes No
Latex/rubber_________________________ Yes No
Other: ____

DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:

Rheumatic heart disease or rheumatic fever Yes No
Scarlet fever_________________________ Yes No
Heart defect or heart murmur____________ Yes No
Heart trouble, heart attack, or angina______ Yes No
Chest pain___________________________Yes No
Shortness of breath___________________ Yes No
Pacemaker___________________________ Yes No
Heart surgery________________________ Yes No
High/Low blood pressure_______________ Yes No
Congenital heart problem ______________ Yes No
Swelling of feet, ankles, hands___________ Yes No
Hepatitis, jaundice, or liver disease _______ Yes No
Stroke ______________________________Yes No
Sinus trouble _________________________ Yes No
Lung or breathing problems _____________Yes No
Asthma or hay fever ___________________Yes No
Hives or skin rash _____________________Yes No
Fainting or dizzy spells _________________Yes No
Diabetes ____________________________Yes No
AIDS or HIV infection __________________Yes No
Chronic Prednisone use ________________Yes No
Thyroid problems _____________________Yes No
Allergies _____________________________Yes No
Arthritis or rheumatism _________________Yes No
Joint replacement or implant ____________ Yes No
Date: __________________
Stomach ulcer _______________________ Yes No
Kidney trouble _______________________ Yes No
Tuberculosis _________________________Yes No
Persistent cough ______________________ Yes No
Cough that produces blood _____________ Yes No

*******TURN OVER TO COMPLETE*******

____
Patient Number

Health/Dental History

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Patient Name: ______________________
Date of Birth: ________________

Chemotherapy (cancer, leukemia) ________ Yes No
Sexually transmitted disease ____________ Yes No
Epilepsy or seizures __________________ Yes No
Anemia ____________________________ Yes No
Glaucoma __________________________ Yes No
Nervousness ______________________ Yes No
Tonsillitis __________________________ Yes No
Tumors ____________________________ Yes No
Mental health care ___________________ Yes No
Back problems ______________________ Yes No
Chemical dependency ________________ Yes No
Mitral valve prolapse _________________ Yes No
Cortisone treatment __________________ Yes No
Cold sores/fever blisters _______________ Yes No
Hypoglycemia ______________________ Yes No
Eating disorders ______________________ Yes No

PATIENT DENTAL HISTORY

Reason for this visit? _______________________________
Previous dentist? ___________________________________
Last dental visit: ___________________________________
What was done? ____________________________________
How often did you visit the dentist before then? ___________
Have you had a complete set of films? _________________
Where? _________________ When? ________________
How often do you brush your teeth? ____________________
How often do you floss? ______________________________
Is your drinking water fluoridated? _____________________

Do your gums bleed while brushing/flossing? Yes No
Teeth sensitive to hot/cold? _____________ Yes No
Teeth sensitive to sweet/sour? ___________ Yes No
Do you feel pain to any of your teeth? _____ Yes No
Do you have any sores in/near your mouth? Yes No
Have you had any head/neck/jaw injuries? _ Yes No
Have you had any of the following problems with your jaw?
- Clicking _______________________ Yes No
- Pain (joint, ear, side of face) ________ Yes No
- Difficulty in opening or closing _______ Yes No
- Difficulty in chewing ______________ Yes No

Do you have frequent headaches? _______ Yes No
Do you clench or grind your teeth? _______ Yes No
Do you bite your lips or cheeks frequently? _ Yes No
Have you noticed loosening of your teeth? _ Yes No
Does food get caught between your teeth? _ Yes No
Have you had periodontal (gum) treatment? Yes No
Ever worn a nightguard or other appliance? Yes No

Have you ever had any difficult extractions? Yes No
Prolonged bleeding following extractions? __Yes No
Do you wear partial or full dentures? ______ Yes No
Date of placement: _________________
Have you ever received oral hygiene instructions regarding the care of your teeth and gums? ___________ Yes No

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE?
____
____

AUTHORIZATION AND RELEASE

I certify that the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of my treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the community health center any insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I certify that I have read and understand the above information to the best of my knowledge.

X _______________________________ **DATE** ________
Signature of patient or parent/guardian if patient is a minor

DOCTOR'S COMMENTS:
____
____
____
____

ASA I II III IV

______________________________ ______________
SIGNATURE **DATE**

____
Patient Number

Health/Dental History