

Patient Name: _____ Date of Birth: _____ Date: _____

Please answer these questions as best you can. We want to know your special needs so we can give you the best care. Please check the answer that is right for you, "Yes", "No", "DK" (Don't Know.) Your answers are confidential and for our records only. - - - BLACK OR BLUE PEN ONLY - - -

Medical

Yes No DK

Has there been a major change to your health within the past year?

Are you under the care of a physician or are you receiving ongoing medical care?

Name and address of your physician: _____

Physician's Phone Number: _____

Date of your last medical visit: _____

Are you pregnant?

If Yes, due date: _____

Do you have any artificial joints, valves, implants, or prosthesis?

Have you had surgery, x-ray treatment, or chemotherapy for a tumor, growth, or other condition?

If yes, please explain: _____

Medications:

Please check the answer that is right for you, "Yes", "No", "DK" (Don't Know):

Yes	No	DK	Yes	No	DK			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	Nitroglycerine.....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Hormone Therapy.....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Antihistamines	<input type="checkbox"/>	<input type="checkbox"/>	Anticoagulants (Blood Thinners).....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Digitalis	<input type="checkbox"/>	<input type="checkbox"/>	Tranquilizers	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Birth Control.....	<input type="checkbox"/>	<input type="checkbox"/>	Insulin (Orinase)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa	<input type="checkbox"/>	<input type="checkbox"/>	Synthroid	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone (steroids)	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin.....	<input type="checkbox"/>	<input type="checkbox"/>			

Please list the drug name, dosage, and frequency:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Dental

Yes No DK

Are you having any discomfort at this time?.....

If yes, please explain: _____

Have you ever had serious trouble associated with previous dental work?

If yes, please explain: _____

Does dental work make you nervous?

Have you ever had any abnormal bleeding associated with previous extractions, surgery, or trauma?

If yes, please explain: _____

Date of your last dental visit: _____

How often do you brush your teeth? _____

How often do you floss your teeth? _____

Allergies:

Please check the answer that is right for you, "Yes", "No", "DK" (Don't Know):

Yes	No	DK	Yes	No	DK			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Local Anesthetics.....	<input type="checkbox"/>	<input type="checkbox"/>	Sedatives, Barbiturates, or Sleeping Pills.....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Latex.....	<input type="checkbox"/>	<input type="checkbox"/>	Iodine.....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin or other antibiotics.....	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin.....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa Drugs.....	<input type="checkbox"/>	<input type="checkbox"/>	Other _____		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Codeine or other narcotics.....	<input type="checkbox"/>	<input type="checkbox"/>			

Other:

Please check the answer that is right for you, "Yes", "No", "DK" (Don't Know):

Yes No DK

Do you use tobacco?.....

What? _____ How much? _____

Do you use alcohol?.....

What? _____ How much? _____

Do you have any CURRENT/PAST history of substance use?

If yes, please explain: _____

Patient Name: _____ Date of Birth: _____ Date: _____

Medical Information:

Please check the answer that is right for you, "Yes", "No", "DK" (Don't Know).

<p>Heart and Circulatory Problems</p> <p>Yes No DK</p> <p>Heart Attack <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>High Blood Pressure..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Chest Pain (Angina) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Heart Murmurs..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Artificial Valves <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Other Heart Problems..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p>Stomach Problems</p> <p>Yes No DK</p> <p>Stomach Pain <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Heartburn..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>History of Ulcers <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Colitis..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p>Neurologic Problems</p> <p>Yes No DK</p> <p>Epilepsy/Seizures <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Chronic Headaches <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>History of Head Injury..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Numbness of Arms, Legs, Hands or Feet <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>History of Stroke..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Fainting Spells..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
<p>Yes No DK</p> <p>Diabetes - Type I <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Diabetes - Type II <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Thyroid Problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Other Gland Problems.... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p>Mental Health Problems</p> <p>Yes No DK</p> <p>Depression <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Anxiety..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>History of Psychiatric Medications <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p>Blood Problems</p> <p>Yes No DK</p> <p>Bleeding Problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Anemia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Hemophilia..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
<p>Breathing/Lung Problems</p> <p>Yes No DK</p> <p>Hay Fever <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Shortness of Breath..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Persistent Cough..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Positive Test/Treatment for Tuberculosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Seasonal Allergies..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Asthma <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Emphysema..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Coughing up Blood <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p>Muscle and Bone Problems</p> <p>Yes No DK</p> <p>Joint/Back Pain..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>History of Broken Bones <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Joint Swelling..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Arthritis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p>Other</p> <p>Yes No DK</p> <p>Domestic Abuse..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Immune System Disorders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Venereal Disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>AIDS/HIV <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Kidney or Bladder Problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Frequent Urinary Tract Infections <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Pregnant..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
<p>Skin Problems</p> <p>Yes No DK</p> <p>Rashes <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Mole Changes <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p>Liver</p> <p>Yes No DK</p> <p>Hepatitis A, B, or C <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Alcoholic Liver Disease..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Other Liver Disease..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Jaundice <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p>Do you have any other disease, condition or problem not listed? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>If Yes, please explain _____</p>

I understand that, to the best of my knowledge, all of the proceeding answers are true and correct. If I ever have any change in my health or medications, I will inform my health care provider immediately. I hereby give my consent to treatment for myself, or the named patient (of whom I am the parent, legal guardian, or foster parent) to the Community Health Center/Dental Center of Burlington.

We have reserved your appointment time for you alone and it is most important that you keep your appointment. If you must cancel your appointment, we require 24-hour notice by phone or in person. If you fail to keep your appointment and do not notify us, you will not be able to reschedule your appointment and you will have to call for a Same Day appointment. Failure to keep a second appointment without 24-hour notice may be grounds for termination of your patient status at the Dental Center of Community Health Center of Burlington. If you're late for your appointment, your dentist may need to reschedule your appointment to allow enough time for treatment. Your cooperation with our appointment policy is appreciated by our entire staff.

Signature of patient or guardian

Date

Signature of Doctor

Date