Staff Initials: _____

Community Health Centers

Dental ■ Patient Medical History Form

617 Riverside Avenue Burlington, VT 05401 Fax: (802) 652-1056 Dental: (802) 652-1050 dentaltriage@chcb.org www.chcb.org

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Preferred Name or Nickname: _____

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? ☐ ☐ ☐

If yes, please explain: _____

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

Name of your physician: _____

Physician's Phone Number: _____

Date of your last medical visit: _____

Are you pregnant? ☐ ☐ ☐

If Yes, due date: _____

Do you breast feed? ☐ ☐ ☐

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

Have you ever been told you need to be pre-medicated prior to dental treatment? ☐ ☐ ☐

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

If yes, please explain: _____

Dental

Yes No DK

Are you having any dental discomfort at this time? ☐ ☐ ☐

If yes, please explain: _____

Have you ever had serious trouble 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? _____

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 abuse? ☐ ☐ ☐ If yes, please explain: _____

Medications

Are you taking any prescription or over-the-counter medications? **Yes** ☐ **No** ☐ **DK** ☐

Please list all medications you are taking (Please include prescription and non-prescription medications):

	Medication:	Dosage:	How Often Taken:	Reason for Medication:
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

Allergies

Are you allergic to anything? **Yes** ☐ **No** ☐ **DK** ☐

Please list all allergies including reaction:

	Allergy to:	Reaction:
1.		
2.		
3.		
4.		

Patient Name: _____ Date of Birth: _____ Today's Date: _____

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

Heart and Circulatory Problems

	Yes	No	DK
Heart Attack	☐	☐	☐
If yes, when _____			
High Blood Pressure	☐	☐	☐
Chest Pain (Angina)	☐	☐	☐
Heart Murmurs	☐	☐	☐
Artifical Valves	☐	☐	☐
Other Heart Problems	☐	☐	☐

Comments _____

	Yes	No	DK
Diabetes - Type I	☐	☐	☐
Diabetes - Type II	☐	☐	☐
Thyroid Problems	☐	☐	☐
Other Gland Problems	☐	☐	☐

Comments _____

Breathing/Lung Problems

	Yes	No	DK
Hay Fever	☐	☐	☐
Shortness of Breath	☐	☐	☐
Persistent Cough	☐	☐	☐
Positive Test/Treatment for Tuberculosis	☐	☐	☐
Seasonal Allergies	☐	☐	☐
Asthma	☐	☐	☐
Emphysema	☐	☐	☐
Coughing up Blood	☐	☐	☐

Comments _____

Skin Problems

	Yes	No	DK
Rashes	☐	☐	☐
Mole Changes	☐	☐	☐

Comments _____

Stomach Problems

	Yes	No	DK
Stomach Pain	☐	☐	☐
Heartburn	☐	☐	☐
History of Ulcers	☐	☐	☐
Colitis	☐	☐	☐

Comments _____

Mental Health Problems

	Yes	No	DK
Depression	☐	☐	☐
Anxiety	☐	☐	☐
History of Psychiatric Medications	☐	☐	☐

Comments _____

Muscle and Bone Problems

	Yes	No	DK
Joint/Back Pain	☐	☐	☐
History of Broken Bones	☐	☐	☐
Joint Swelling	☐	☐	☐
Arthritis	☐	☐	☐

Comments _____

Liver

	Yes	No	DK
Hepatitis A, B, or C	☐	☐	☐
Alcoholic Liver Disease	☐	☐	☐
Other Liver Disease	☐	☐	☐
Jaundice	☐	☐	☐

Comments _____

Neurologic Problems

	Yes	No	DK
Epilepsy/Seizures	☐	☐	☐
Chronic Headaches	☐	☐	☐
History of Head Injury	☐	☐	☐
Numbness of Arms, Legs, Hands or Feet	☐	☐	☐
History of Stroke	☐	☐	☐
If yes, when _____			
Fainting Spells	☐	☐	☐

Comments _____

Blood Problems

	Yes	No	DK
Bleeding Problems	☐	☐	☐
Anemia	☐	☐	☐
Hemophilia	☐	☐	☐
Are you taking blood thinners?	☐	☐	☐
If yes, recent INR level _____			

Comments _____

Other

	Yes	No	DK
Domestic Violence	☐	☐	☐
Immune System Disorders	☐	☐	☐
Venereal Disease	☐	☐	☐
AIDS/HIV	☐	☐	☐
Kidney or Bladder Problems	☐	☐	☐
Frequent Urinary Tract Infections	☐	☐	☐

Comments _____

Do you have any other disease, condition or problem not listed? ☐ ☐ ☐

If Yes, please explain _____

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 Centers.

We set aside time just for you. If you're running late or must change an appointment, please call us as soon as possible. Arriving late may require your provider to reschedule your visit to allow enough time for your care. If you miss an appointment, you may have to wait for another opening. If you miss three appointments, you may be only able to make same-day appointments. By calling us when you are unable to make your scheduled appointment, we are able to see other patients waiting for an appointment. These rules are firm so that we can serve everyone in need of care.

Signature of Patient or Guardian Date

Signature of Hygienist ☐ Not Applicable

Signature of Dentist Date ☐ Supervising ☐ Treating