

# FAMILY HEALTH CENTER OF SOUTHERN OKLAHOMA

## DENTAL HEALTH HISTORY

*The benefits of a happy, healthy smile are immeasurable. Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. If you need assistance with the form, we will be happy to help you. The better we communicate, the better we can care for you.*

### All About You

Name: \_\_\_\_\_  
I prefer to be called: \_\_\_\_\_  
Birthdate: \_\_\_\_\_  
Home #: \_\_\_\_\_  
Cell #: \_\_\_\_\_

Date: \_\_\_\_\_  
Chart Number: \_\_\_\_\_  
Male \_\_\_\_\_ Female \_\_\_\_\_  
Work #: \_\_\_\_\_  
Ext.: \_\_\_\_\_

Other family members seen in our dental clinic: \_\_\_\_\_  
Previous/Past Dentist: \_\_\_\_\_  
Date of last dental visit: \_\_\_\_\_

*In the event of an emergency, who should we contact:*

Name: \_\_\_\_\_  
Relation: \_\_\_\_\_  
Home #: \_\_\_\_\_  
Work #: \_\_\_\_\_

Results from patient evaluation for communication barriers: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Dental History

Why have you come to the dentist today?  
\_\_\_\_\_  
\_\_\_\_\_

Are you experiencing dental pain? Yes \_\_\_\_\_ No \_\_\_\_\_  
Explain: \_\_\_\_\_

Date of last dental visit: \_\_\_\_\_

Have you ever had a serious/difficult problem associated with any previous dental work?

No \_\_\_\_\_ Yes \_\_\_\_\_ Explain: \_\_\_\_\_

Do you experience jaw joint discomfort (TMJ, TMD)? \_\_\_\_\_

Your current dental health is:

Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_

Do you like your smile? \_\_\_\_\_

Do your gums bleed? \_\_\_\_\_

How many times a day do you brush? \_\_\_\_\_

What type of bristles do you use? Hard \_\_\_\_\_ Medium \_\_\_\_\_ Soft \_\_\_\_\_

Do you floss? Yes \_\_\_\_\_ No \_\_\_\_\_ How often? \_\_\_\_\_

What type water do you drink? Bottled \_\_\_\_\_ City (name) \_\_\_\_\_ Well \_\_\_\_\_

**Medical History**

Do you have a personal physician? Yes \_\_\_\_\_ No \_\_\_\_\_ Name: \_\_\_\_\_

Phone #: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Your current health is: Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_

Is your physician treating you for a specific condition? Yes \_\_\_\_\_ No \_\_\_\_\_

Please explain, if yes: \_\_\_\_\_

List all current medications and dosages: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Females only:**

Are you pregnant? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, week # \_\_\_\_\_

Are you nursing? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you taking birth control pills? Yes \_\_\_\_\_ No \_\_\_\_\_

Please check any condition you currently have or have had in the past.

**Cardiovascular:**

Heart failure \_\_\_\_\_ Heart disease or attack \_\_\_\_\_ Angina pectoris (chest pain) \_\_\_\_\_  
High blood pressure \_\_\_\_\_ Low blood pressure \_\_\_\_\_ Heart murmur \_\_\_\_\_  
Mitral valve prolapse \_\_\_\_\_ Rheumatic fever \_\_\_\_\_ Congenital heart defect \_\_\_\_\_  
Artificial heart valve \_\_\_\_\_ Arrythmias \_\_\_\_\_ Heart pacemaker/defibrillator \_\_\_\_\_  
Heart transplant \_\_\_\_\_ Heart surgery \_\_\_\_\_ Prior Phen-fen use \_\_\_\_\_  
Stroke \_\_\_\_\_ Aneurysm \_\_\_\_\_ Other heart problems \_\_\_\_\_

**Hematologic:**

Blood transfusion \_\_\_\_\_ Anemia \_\_\_\_\_ Hemophilia \_\_\_\_\_  
Leukemia \_\_\_\_\_ Sickle cell disease \_\_\_\_\_ Tendency to bleed longer \_\_\_\_\_

**Neural and sensory:**

Eye pain \_\_\_\_\_ Vision problems \_\_\_\_\_ Glaucoma or cataracts \_\_\_\_\_  
Earaches \_\_\_\_\_ Ringing in ears \_\_\_\_\_ Hearing loss \_\_\_\_\_  
Severe headaches \_\_\_\_\_ Fainting/dizziness \_\_\_\_\_ Epilepsy \_\_\_\_\_  
Nervousness \_\_\_\_\_ Psychiatric treatment \_\_\_\_\_ Development delayment \_\_\_\_\_

**Gastrointestinal**

Stomach ulcers \_\_\_\_\_ Gastritis \_\_\_\_\_ Colitis \_\_\_\_\_  
Persistent diarrhea \_\_\_\_\_ Liver disease \_\_\_\_\_ Yellow jaundice \_\_\_\_\_  
Cirrhosis \_\_\_\_\_ Hepatitis \_\_\_\_\_ Hep A \_\_\_\_\_ Hep B \_\_\_\_\_ Hep C \_\_\_\_\_

**Respiratory**

Hay fever \_\_\_\_\_ Sinusitis \_\_\_\_\_ Seasonal allergies \_\_\_\_\_  
Asthma \_\_\_\_\_ Chronic cough \_\_\_\_\_ Emphysema \_\_\_\_\_  
Tuberculosis (TB) \_\_\_\_\_ Breathing difficulty (COPD) \_\_\_\_\_ Supplemental oxygen \_\_\_\_\_

**Endocrine**

Diabetes \_\_\_\_\_ Insulin-dependent (IDDM) \_\_\_\_\_ Non-insulin dependent (NIDDM) \_\_\_\_\_  
Thyroid disease \_\_\_\_\_ Hyper-thyroidism \_\_\_\_\_ Hypo thyroidism \_\_\_\_\_

**Urinary / Sexually Transmitted Diseases**

Urinate frequently \_\_\_\_\_ Kidney problems \_\_\_\_\_ Bladder problems \_\_\_\_\_  
Sexually transmitted disease (STD: syphilis, gonorrhea, chlamydia, genital herpes) \_\_\_\_\_  
HIV-Positive \_\_\_\_\_ AIDS (or exposure) \_\_\_\_\_

**Dermal / Skeletal**

Latex allergy _____	Abnormal mole _____	Osteoporosis _____
Sore muscles _____	Stiff joints _____	Arthritis _____
Artificial joint _____	Fever blisters _____	Mouth ulcers (canker sores) _____

**Other conditions**

Frequent sore throats _____	Enlarged lymph node _____	Tumor or cancer _____
Radiation treatment _____	Chemotherapy _____	Surgical removal of tumor _____
Use tobacco _____	Smokeless tobacco _____	Cigarettes/Cigars _____
# Packs per day (PPD) _____	# years tobacco used _____	Alcohol use _____
Drug addiction _____	Steroid therapy _____	Other conditions _____

**Drug allergies**

Aspirin _____	Codeine _____	Penicillin _____	Erythromycin _____
Sulfa _____	Tetracycline _____	Latex _____	Dental anesthetic _____
Other _____	No Known Drug Allergies (NKDA) _____		

*I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.*

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Reviewed by:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_