Name: Mister Marlboro
Date of Birth: 1997-08-07

Provider Name: Laura Brown
Current Date: 2019-06-05

Thank you for your honest answers. This information is confidential.

Are you completing this form for someone else?

○ Yes ◉ No

Did an English language interpreter help you with this form?

○ Yes ◉ No

Is this a new or updated health history?

◉ New ○ Updated

Have you ever been told by a doctor to take medication before dental treatment?

○ Yes ◉ No

Medical History

Breathing Problems

Kidney or Urinary Problems

Kidney disease

◉ No ○ Unsure ○ Yes

Other nervous system problems

○ Yes ○ No ○ Unsure

Tuberculosis

○ Unsure ○ Yes ◉ No

Other breathing problems

○ Unsure ○ Yes ◉ No

Heart or Circulation Problems

Bronchitis

○ Unsure ○ Yes ◉ No

Nose or sinus problems

◉ No ○ Unsure ○ Yes

Angina or chest pain

◉ No ○ Unsure ○ Yes

Rheumatic heart disease / fever

○ Yes ◉ No ○ Unsure

Mitral valve prolapse

◉ No ○ Unsure ○ Yes

Dialysis

○ Unsure ○ Yes ◉ No

Transitory ischemic attack (TIA)

○ Unsure ○ Yes ◉ No

Hormone or Gland Problems

Hives or skin rash

○ Unsure ○ Yes ◉ No

Allergic Reactions or Other Problems

Asthma

○ No ○ Unsure ◉ Yes

Details

Mild, with activity

Heart surgery or other procedure

○ Yes ○ Unsure ◉ No

Head and Neck Problems

Emphysema

○ Yes ◉ No ○ Unsure

COPD

○ Unsure ○ Yes ◉ No

Shortness of breath

○ Unsure ○ Yes ◉ No

Sleep apnea

○ Yes ◉ No ○ Unsure

High blood pressure (hypertension)

○ Unsure ◉ Yes ○ No

Details

Monitored by physician. No medication at this time

Heart attack

○ Unsure ○ Yes ◉ No

Irregular heartbeat

○ Yes ◉ No ○ Unsure

Damage to heart valves

○ Yes ○ Unsure ◉ No

Endocarditis (infected heart valve)

○ Yes ○ Unsure ◉ No

Congestive heart failure

○ Unsure ○ Yes ◉ No

Swollen ankles

○ Yes ○ Unsure ◉ No

Have you ever taken the drugs Fenfluramine (Fen-phen), Pondimin, or Dexfenfluramine (Redux)

○ Yes ◉ No ○ Unsure

Other heart of circulation problems

○ Unsure ○ Yes ◉ No

Frequent urination

○ Yes ○ Unsure ◉ No

Other kidney problems

○ Unsure ○ Yes ◉ No

Nervous System Problems

Stroke

○ Unsure ○ Yes ◉ No

Fainting spells

○ Unsure ○ Yes ◉ No

Convulsions, seizures, epilepsy

○ Unsure ○ Yes ◉ No

Parkinson's Disease

○ Yes ◉ No ○ Unsure

Nose or sinus problems

○ Yes ○ Unsure ◉ No

Swollen glands

○ Unsure ○ Yes ◉ No

Oral cancer

○ Yes ◉ No ○ Unsure

Impairment of hearing, sight or speech

○ Yes ◉ No ○ Unsure

Glaucoma

○ Yes ○ Unsure ◉ No

Head and neck radiation therapy

◉ No ○ Unsure ○ Yes

Jaw joint (TMJ) problems

◉ No ○ Unsure ○ Yes

Have you ever had a severe injury to your face, teeth or jaw?

○ Yes ◉ No ○ Unsure

Other head and neck problems

◉ No ○ Unsure ○ Yes

Thyroid disease (hypothyroidism, hyperthyroidism)

○ Yes ◉ No ○ Unsure

Diabetes

○ No ○ Unsure ◉ Yes

Select all that apply

☐ Pre-diabetic ☐ Medicine-controlled diabetic ☐ Insulin-controlled diabetic
☑ Diet-controlled diabetic

Hypoglycemia (low blood sugar)

○ Unsure ○ Yes ◉ No

Adrenal disease

○ Unsure ○ Yes ◉ No

Pancreatic disease

○ Yes ◉ No ○ Unsure

Other hormone / gland disease

○ Unsure ○ Yes ◉ No

Arthritis

◉ No ○ Unsure ○ Yes

Osteoporosis / osteopenia

◉ No ○ Unsure ○ Yes

Artificial joint placement

○ Unsure ◉ Yes ○ No

Details

Knee replaced from injury 2005. No premedication necessary.

Skin cancer

○ Unsure ○ Yes ◉ No

Back problems

○ Unsure ○ Yes ◉ No

Fibromyalgia

○ Yes ◉ No ○ Unsure

Have you taken or been administered medications (by mouth, injection or IV) to control bone loss? (eg. Fosamax, Boniva)

○ Yes ◉ No ○ Unsure

Other muscle, bone or skin disease

◉ No ○ Unsure ○ Yes

Muscle, Bone or Skin Problems

Stomach, Liver or Intestinal Problems

Liver disease

○ Yes ◉ No ○ Unsure

Hepatitis

○ Yes ◉ No ○ Unsure

Ulcers

○ No ○ Unsure ◉ Yes

Details

Occasional oral ulcers, aggravated by salty and acidic foods

Seasonal allergies

◉ Yes ○ No ○ Unsure

Details

hay fever

Allergy or reaction to codeine

○ Unsure ○ Yes ◉ No

Allergy or reaction to local anesthetic

○ Unsure ○ Yes ◉ No

Blood or Immune System Problems

Current Medications

Acid reflux (GERD)

○ Yes ○ Unsure ◉ No

Eating disorder

○ Yes ◉ No ○ Unsure

Other stomach, liver or intestinal problems

◉ No ○ Unsure ○ Yes

Allergy or reaction to penicillin

◉ No ○ Unsure ○ Yes

Allergy or reaction to erythromycin

○ Yes ◉ No ○ Unsure

Allergy or reaction to latex

○ Unsure ◉ Yes ○ No

Details

Mild rash

Allergy or reaction to foods/flavors

◉ No ○ Unsure ○ Yes

Other substances

○ Unsure ○ Yes ◉ No

Cancer of any type

○ Unsure ○ Yes ◉ No

Organ or bone marrow transplant

○ Unsure ○ Yes ◉ No

Lupus

○ Unsure ○ Yes ◉ No

Multiple sclerosis

○ Yes ○ Unsure ◉ No

Anemia

○ Unsure ○ Yes ◉ No

Hemophilia

○ Unsure ○ Yes ◉ No

AIDS/HIV

○ Unsure ○ Yes ◉ No

Frequent nosebleeds, increased bruising or bleeding

○ Yes ○ Unsure ◉ No

Autoimmune disease

○ Unsure ○ Yes ◉ No

Sjorgen's disease

◉ No ○ Unsure ○ Yes

Chemotherapy treatment

○ Yes ◉ No ○ Unsure

Radiation treatment

◉ No ○ Unsure ○ Yes

Other problems with the blood or immune system

◉ No ○ Unsure ○ Yes

Have you been prescribed medical marijuana

○ Yes ◉ No ○ Unsure

Do you take any blood thinners?

○ Unsure ○ Yes ◉ No

Have you had chemotherapy or radiation therapy

○ Yes ◉ No ○ Unsure

Other problems with the blood or immune system

○ Yes ◉ No ○ Unsure

Please list all prescription and over the counter medications, including supplements and other substances you are taking at this time

Daily multi-vitamin

Dental History

TMJ

Do you have any dental anxiety?

☐ Yes ☑ No ☐ Unsure

What is the reason for your last dental visit?

☐ Procedure (filling, cleaning) ☐ Orthodontics ☑ Check-up examination ☐ Other
☐ Emergency treatment (extraction, root canal)

Have you ever had any problems following dental treatment?

○ Yes ◉ No

Have you ever had any problems or unusual reaction to local anesthetic (freezing)?

○ Yes ◉ No

Have you ever had surgery in your mouth or on your lips?

☐ Yes ☑ No

Have you ever had periodontal treatment to your gums?

☐ Yes ☑ No

Have you ever had orthodontic treatment to straighten your teeth?

☐ No ☑ Yes

Specify

Full brackets removed 2015

Have you ever had any missing teeth replaced with a removable denture, fixed bridge or implant?

☐ Yes ☑ No

Have you ever worn a bitesplint / nightguard?

☐ Yes ☑ No

Current Dental Concerns

Have you ever had extraction (pulling) of any teeth?

☐ Yes ☑ No

Have you ever had endodontic treatment (root canal) of any teeth?

☐ Yes ☑ No

Have you had a recent toothache?

☐ Yes ☑ No

Are your teeth sensitive?

☐ Yes ☑ No

Do you have bleeding gums?

☐ No ☑ Yes

Specify

Only when flossing

Do you have trouble chewing?

☐ Yes ☑ No

Do you clench or grind your teeth?

☐ Yes ☑ No

Do you have difficulty opening your mouth as wide as you would like?

☐ Yes ☑ No

Do your jaw joints or muscles hurt?

☐ Yes ☑ No

Does your jaw click, pop or lock when you chew?

☐ Yes ☑ No

Do you experience a dry mouth?

☐ Yes ☑ No

Do you have sores in or around your mouth?

☐ Yes ☑ No

When was the last time your teeth were cleaned at a dental office?

○ Less than one year ◉ More than one year, but less than 2 ○ More than 2 years

When was the last time you had dental x-rays?

○ Less than one year ◉ More than one year, but less than 2 ○ More than 2 years

Are you happy with the appearance of your teeth?

☑ Yes ☐ No

How much sugar do you consume daily?

◉ More than 14 cubes ○ Less than 14 cubes

How often do you brush your teeth?

○ Not every day ◉ Once daily ○ Twice or more every day

Specify

◉ AM ○ PM

How often do you floss your teeth?

○ Never ◉ Weekly ○ Daily

Do you have any questions or additional information you would like us to know before we treat you?

☐ Yes ☑ No

Mental Health

Depression

◉ No ○ Unsure ○ Yes

Feelings of anxiety

○ Yes ○ Unsure ◉ No

ADD/ADHD (attention deficit disorder)

○ Yes ◉ No ○ Unsure

Bipolar / Manic depression

○ Yes ○ Unsure ◉ No

Schizophrenia

○ Yes ○ Unsure ◉ No

Alzheimer's

○ Unsure ○ Yes ◉ No

Dementia / Delirium

○ Unsure ○ Yes ◉ No

Other

○ Unsure ○ Yes ◉ No

Do you have chronic pain?

○ Unsure ○ Yes ◉ No

Personal History

Do you have a family history of:

☐ Heart disease ☐ Stroke ☐ Diabetes ☐ Cancer ☐ Autoimmune disease

Do you exercise regularly?

○ Unsure ○ Yes ◉ No

Do you play contact sports?

○ Yes ○ Unsure ◉ No

Have you ever been hospitalized, had major surgery or been seriously hurt?

○ Yes ◉ No ○ Unsure

Have you had or do you have any sexually transmitted diseases/infections?

(●) No ( ) Unsure ( ) Yes

Do you have any special accommodations for dental treatment?

(●) No ( ) Unsure ( ) Yes

Are you pregnant?

( ) Unsure ( ) Yes (●) No

Are you nursing?

( ) Yes (●) No

Do you use tobacco?

(●) Yes ( ) No

Select all that apply

[ ] Cigars [ ] Pipes [ ] e-Cigarettes [ ] Chew / Snuff [ ] Hookah [✓] Cigarettes

Cigarettes smoked per day

( ) 0-10 ( ) 21+ (●) 11-20

Have you tried to quit before?

(●) Yes ( ) No

It can take an average of 6 tries to quit for good. Every quit attempt is a chance to learn.

Are you interested in quitting in the next 30 days?

(●) Yes ( ) No ( ) Probably not ( ) Unsure

Congratulations! Quitting smoking is the most important thing you can do for your oral health.
Planning your quit and setting a quit date are helpful steps. Have you set a quit date yet?
Support at the free Quitline and/or medication may increase your chances of success. Ask for a brochure for more information.

Do you drink alcoholic beverages?

( ) No (●) Yes

On average how many drinks do you have in a week?

( ) 1-2 ( ) 3-4 ( ) 5-6 (●) 7+

Do you use prescription, street drugs or other substances for recreational use?

(●) Yes ( ) No

Select all that apply

[ ] Anxiety medication [ ] Cocaine [✓] Marijuana [ ] Pain medication [ ] Heroine
[ ] Other

Have you ever been in an alcohol or substance abuse program?

( ) Yes ( ) Unsure (●) No

Do you have any mental health problems?

( ) Yes (●) No ( ) Unsure

When was your last visit to a physician (medical doctor)?

2018

Examiner Comments

Do you have a primary medical care provider? (doctor or clinic)

○ Unsure ○ Yes ◉ No

I certify to the best of my knowledge the above information is complete and accurate.
The health history form should be updated every 6 months and a new form must be filled out ever 2 years.

Patient Signature

>

Print your name: Mister Marlboro

Date: 2019-06-05 11:08 AM

Witness Signature

>

Print your name: Laura Brown

Date: 2019-06-05 11:08 AM