United Community Health Center
Working Together for Health

MEDICAL and DENTAL HISTORY

Patient's First & Last Name:_____Today's Date:_____
Date of Birth:_____/_____/_____ Race:_____ Gender: ☐ Male ☐ Female ☐ Unknown

Are you currently under the care of a physician? ☐ **YES** ☐ **NO**
Date of last visit:_____ Reason:_____
Name of physician:_____ Phone:_____
Address:_____

Dental History

Purpose of your visit:_____
Are you receiving routine dental care: ☐ **YES** ☐ **NO** Date of last visit:_____
Reason for last visit:_____
Name of dentist:_____

Have any of the following prevented you from seeking dental care?

- ☐ Fear or anxiety
- ☐ Lack of time
- ☐ Lack of funds/cost
- ☐ No insurance
- ☐ No transportation
- ☐ Other _____

Hygiene Practices

How many times did you brush per day?_____
How many times do you floss per day?_____
Is your tooth brush: ☐ Hard ☐ Medium ☐ Soft
Do you use daily mouth rinse?_____
Toothpaste Brand Name_____

- ☐ Flouride
- ☐ Tartar Contol
- ☐ Whitening
- ☐ ADA Aprove
- ☐ other _____

Yes	No	
☐	☐	Did you drink fluoridated water as a child?
☐	☐	Do your gums Bleed when you brush or Floss
☐	☐	Does your food or floss catch between your teeth
☐	☐	Have you ever had a periodontal (gum) treatment
☐	☐	Have you ever had any orthodontic (braces) treatment
☐	☐	Are your teeth sensative to sweets,cold,hot, or pressure

Yes	No	Salivary Functions
☐	☐	Does your mouth often feels dry?
☐	☐	Do You have difficulty swallowing?
☐	☐	Do you have difficulty chewing food

Medical History

YES	NO	CARDIOVASCULAR CONDITIONS
☐	☐	Angina/Chest Pain/Pain on exertion
☐	☐	Atherosclerosis/Hardening of arteries
☐	☐	Artificial Heart Valve date:_____
☐	☐	Internal Defibrillator Date:_____
☐	☐	Heart Attack Date:_____
☐	☐	Heart Murmur
☐	☐	High Blood Pressure
☐	☐	Low blood pressure
☐	☐	Congenital heart defect
☐	☐	Mitral valve prolase
☐	☐	Bypass surgery Date:_____
☐	☐	Pacemaker Date:_____
☐	☐	Swelling of ankles
☐	☐	Shortness of breath after exercise
☐	☐	Rheumatic fever/ rheumatic heart disease

YES	NO	BONE & JOINT CONDITIONS
☐	☐	Osteoporosis
☐	☐	Osteoarthritis
☐	☐	Traumatic injury
☐	☐	TMJ problems
☐	☐	Jaw surgery
☐	☐	Frequent fractures
☐	☐	Rheumatoid arthritis
☐	☐	Joint replacement

YES	NO	BLOOD ABNORMALITIES
☐	☐	Prolonged bleeding
☐	☐	Anemia
☐	☐	Sickle cell disease:_____ Trait:_____
☐	☐	Hemophilia Type:_____
☐	☐	Blood transfusion Year:_____

☐ ☐ Irregular Heart Beat

YES NO RESPIRATORY CONDITONS

- ☐ ☐ Tuberculosis
- ☐ ☐ Emphysema
- ☐ ☐ Chronic bronchitis
- ☐ ☐ Asthma
- ☐ ☐ Seasonal allergies
- ☐ ☐ Sinusitis
- ☐ ☐ Persistent cough/cough up blood

YES NO GASTROINTESTINAL CONDITIONS

- ☐ ☐ Colon disorders
- ☐ ☐ Persistent diarrhea
- ☐ ☐ Difficulty swallowing
- ☐ ☐ Heartburn
- ☐ ☐ Ulcers
- ☐ ☐ Malnutrition
- ☐ ☐ Jaundice
- ☐ ☐ Gallbladder stones/trouble
- ☐ ☐ Liver disease/Cirrhosis
- ☐ ☐ Hepatitis: A B C

YES NO GENITOURINARY CONDITIONS

- ☐ ☐ Kidney/Bladder infections
- ☐ ☐ Dialysis When?_____

YES NO SEXUALLY TRANSMITTED DISEASE

- ☐ ☐ Type:_____

YES NO OTHER CONDITIONS

- ☐ ☐ Domestic violence victim
- ☐ ☐ Glaucoma
- ☐ ☐ Organ/Tissue transplant
- ☐ ☐ Unintended weight loss
- ☐ ☐ Chronic pain Site:_____

YES NO NEUROLOGICAL CONDITIONS

- ☐ ☐ Epilepsy
- ☐ ☐ Convulsions/Seizures
- ☐ ☐ Stroke
- ☐ ☐ Neuritis
- ☐ ☐ Neuralgia/Facial pain
- ☐ ☐ Numbness/Paralysis
- ☐ ☐ Severe frequent headaches

YES NO PSYCHOLOGICAL CONDITIONS

- ☐ ☐ Depression
- ☐ ☐ Anxiety or panic disorders
- ☐ ☐ Bipolar disease
- ☐ ☐ Eating disorder, anorexia, bullemia
- ☐ ☐ Other

YES NO DERMATOLOGICAL CONDITIONS

- ☐ ☐ Chronic/Recurrent skin rashes
- ☐ ☐ Hives
- ☐ ☐ Psoriasis
- ☐ ☐ Eczema

YES NO IMMUNE CONDITIONS

- ☐ ☐ AIDS or HIV infections
- ☐ ☐ Sarcoidosis
- ☐ ☐ Lupus erythematosis
- ☐ ☐ Immunosupression explain:_____

YES NO CANCER

- ☐ ☐ Site:_____ Type:_____

Yes No Females Only

- ☐ ☐ Post-menopausal or post-hysterectomy
- ☐ ☐ Are you pregnant? Due Date:_____
- ☐ ☐ Are you currently taking birth control mechanism?
- ☐ ☐ Are you currently taking medications for osteoporosis?
- ☐ ☐ Are you currently breasfeeding?

Allergies

Are you allergic to any of the following?

Yes No

- ☐ ☐ Local Anesthitic
- ☐ ☐ Penicillen/Antibiotics
- ☐ ☐ Iodine
- ☐ ☐ Sleeping aid Medications
- ☐ ☐ Sulfa drugs

Yes No

- ☐ ☐ Codine or Narcotics
- ☐ ☐ Latex
- ☐ ☐ Nickel
- ☐ ☐ Aspirin
- ☐ ☐ Other_____

List Of Current Medications Prescribed by a Phycisian

Name of Medication	Dose	Date Started
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand the need for theses questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes in my medical or dental status to the dentist at the earliest possible time, and I agree to do so. I have given permission to the dentist to obtain from my physician any additional information regarding my medical or dental history needed to provide me the best dental treatment possible.

Signature of Patient or legal Guardian:_____Date: _____