

**Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Today’s Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you seeing another doctor at this time?** Yes No **If Yes, why?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Doctor** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you seeing a Dentist?** YES NO **If Yes, who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **Medical History** |
| **Medications** | **Medical History** | **Dental History** |
| List **ALL** medications and dosages:(**include birth control, herbals, vitamins and any over the counter medications**)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Have you ever taken Fosamax, Actonel, Boniva or similar medication? Yes No | ***Have you had any of these problems***: Asthma Yes NoChronic Cough/COPD Yes No Tuberculosis Yes NoLiver Disease Yes No Hepatitis Yes NoSeizures/Epilepsy Yes No Headache/Migraine Yes No History of Fainting Yes No Kidney Disease Yes No Diabetes Yes No High Blood Pressure Yes No Heart Disease/Valve disease Yes NoPacemaker Yes No High Cholesterol Yes No Stroke Yes No Cancer Yes No Radiation or Chemotherapy Yes NoDepression/Anxiety Yes No Bipolar Yes No Schizophrenia Yes No HIV/AIDS Yes No Bleeding or Blood disorders Yes No History of Blood Clot Yes No Blood Transfusion Yes No Thyroid Disease Yes No History of Eye Surgeries Yes No Glaucoma Yes No Hearing Loss or Impairment Yes No Back or Joint pain Yes No Artificial Joints Yes No Osteoporosis/Bone Loss Yes No Drug or Alcohol Dependence Yes No Sexually Transmitted Diseases: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Turn Over To Complete**  | Last Dental Visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do you have Dental Anxiety? Yes No Dental Concerns now: Yes NoIf YES, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Are you currently in **PAIN**? Yes No Numbness or Pain in:  **FACE / NECK /MOUTH** Do you have any **LOOSE** teeth? Yes NoDo your gums **BLEED**? Yes NoDo you **CLENCH** or **GRIND**? Yes No Do you wear **DENTURES**? Yes No If YES, **Partials**  or **Full**Have you had **Braces**? Yes No Do you **Snore**? Yes No Sore/Lesions lasting > 2wks Yes NoHave Chronic Hoarseness? Yes No How often do you brush? \_\_\_\_\_\_\_\_ x Day / WeeklyHow often do you floss? \_\_\_\_\_\_\_\_ x Day / WeeklyDo you regularly drink: Soda: \_\_\_\_\_ x Day No juice: \_\_\_\_\_ x Day No energy drinks: \_\_\_\_\_ x Day No **Other Medical History**Have you had any hospitalizations or surgeries? Yes No Please state reason and date below: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_ \_\_\_\_\_\_\_\_ |
| **Patient Allergies** |
| Penicillin/Amoxicillin: Yes NoErythromycin: Yes NoSulfa: Yes NoLocal Anesthetic: Yes NoCodeine: Yes NoAspirin/Ibuprofen: Yes NoLatex: Yes NoOther medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Food Allergy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Environment Allergy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Vaccine History** |
| Pneumonia Vaccine: Yes NoDate:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Tetanus Vaccine: Yes NoDate:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Influenza Vaccine: Yes NoDate:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Shingles Vaccine: Yes NoDate:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Hepatitis B Series: Yes NoDate:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  **Medical and Social History**  |
| **Screenings** | **Social History Continued…** | **Other Individual History** |
| Regular or Irregular Periods:\_\_\_\_\_\_\_\_\_\_Age of Onset of Period:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last Pelvic Exam: Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last Mammogram:Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last Breast Exam: Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Colon Cancer Testing: Yes No Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Colonoscopy / Stool Sampling for Blood: Yes No If YES, Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Checked for Osteoporosis: Yes NoOther Routine Health Testing: Yes NoType:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Family Health History*****Do any of your family members suffer from any of the following (PLEASE IDENTIFY WHO)*** Hypertension:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Heart Disease:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cancer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Diabetes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Depression: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Thyroid Problems:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Depression:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Anxiety:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Bipolar illness:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Schizophrenia:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Substance Use:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Social History**Caffeine Use (coffee, soda, energy drinks): Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ x Day / WeeklyDo you smoke/chew: Cigarettes: Yes No E-Cigarettes: Yes No Tobacco: Yes NoType/Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Years: \_\_\_\_\_\_\_\_\_\_ Quit? \_\_\_\_\_\_\_\_\_\_\_\_\_ | Alcohol use: Current Past NeverFor **Women**: In the past year, have you had more than 3 drinks of any kind of alcohol in one day or more than 7 in a week? Yes NoFor **Men**: In the past year, have you had more than 4 drinks of any kind of alcohol in one day or more than 14 in a week? Yes No In the past 28 days, have you had any of the following drugs? (**select all that apply**)\_\_\_ Marijuana \_\_\_ Inhalants \_\_\_ Sedatives \_\_\_ Hallucinogens\_\_\_ Cocaine \_\_\_ Opioids \_\_\_ Amphetamines/Stimulants \_\_\_ IV drug use:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**In the last 12 months:** Did you ever eat less than you felt you should because there wasn’t enough money for food? Yes NoHas your utility company shut off your service for not paying your bills? Yes NoHave you needed to see a doctor, but could not because of cost? Yes NoHave you ever had to go without health care because you didn’t have a way to get there?  Yes NoAre you worried that in the next 2 months, you may not have stable housing? Yes No Do you ever need help reading hospital materials? Yes No  Are you afraid you might be hurt in your apartment building or house? Yes No  Do problems getting child care make it difficult for you to work? Or study?  Yes No I don’t have children **If you circled YES to any of these questions, would you like to receive assistance with any of these needs?** Yes No  **Are any of your needs urgent?** (For example, I don’t have food and/or I don’t have a place to sleep tonight) Yes No  | Job:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Place of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Education:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Religion:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Communication or Ambulation Needs:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Pets at Home:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do you Exercise: Yes NoMarital Status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Number of Children:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Number of Pregnancies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Are you Pregnant/Nursing: Yes NoAre you Sexually Active: Yes NoMales, Females, or Both: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Number of Current Partners:\_\_\_\_\_\_\_\_\_\_\_Lifetime Partners: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sexual Orientation:  \_\_\_ Lesbian or Gay  \_\_\_ Straight (not lesbian or gay) \_\_\_ Bisexual  \_\_\_ Something else  \_\_\_ I Don’t Know  \_\_\_ Choose not to disclose  Sex Gender Identity:  \_\_\_ Male  \_\_\_ Female  \_\_\_ Transgender Male/Female-to Male \_\_\_ Transgender Female/Male-to-Female \_\_\_ Other  \_\_\_ Choose not to disclose Are you a Veteran? Yes NoAre you Disabled? Yes NoAdvanced Directives/DNR: Yes No |

**I have answered all questions to the best of my knowledge:**

**Patient/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**