

**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 No  Chronic Cough/COPD Yes No  Tuberculosis Yes No  Liver Disease Yes No  Hepatitis Yes No  Seizures/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 No  Pacemaker Yes No  High Cholesterol Yes No  Stroke Yes No  Cancer Yes No  Radiation or Chemotherapy Yes No  Depression/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 No  If YES, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Are you currently in **PAIN**? Yes No  Numbness or Pain in:  **FACE / NECK /MOUTH**  Do you have any **LOOSE** teeth? Yes No  Do your gums **BLEED**? Yes No  Do 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 No  Have Chronic Hoarseness? Yes No  How often do you brush? \_\_\_\_\_\_\_\_ x Day / Weekly  How often do you floss? \_\_\_\_\_\_\_\_ x Day / Weekly  Do 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 No  Erythromycin: Yes No  Sulfa: Yes No  Local Anesthetic: Yes No  Codeine: Yes No  Aspirin/Ibuprofen: Yes No  Latex: Yes No  Other medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Food Allergy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Environment Allergy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Vaccine History** | |
| Pneumonia Vaccine: Yes No  Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Tetanus Vaccine: Yes No  Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Influenza Vaccine: Yes No  Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Shingles Vaccine: Yes No  Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Hepatitis B Series: Yes No  Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **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 No  Other Routine Health Testing: Yes No  Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **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 / Weekly  Do you smoke/chew:  Cigarettes: Yes No  E-Cigarettes: Yes No  Tobacco: Yes No  Type/Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Years: \_\_\_\_\_\_\_\_\_\_ Quit? \_\_\_\_\_\_\_\_\_\_\_\_\_ | | Alcohol use: Current Past Never  For **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 No  For **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 No  Has your utility company shut off your service for not paying your bills? Yes No  Have you needed to see a doctor, but could not because of cost? Yes No  Have you ever had to go without health care because you didn’t have a way to get there?  Yes No  Are 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 No  Marital Status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Number of Children:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Number of Pregnancies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Are you Pregnant/Nursing: Yes No  Are you Sexually Active: Yes No  Males, 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 No  Are you Disabled? Yes No  Advanced Directives/DNR: Yes No | |

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

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