Medical History

Auburn Centre Dental

1. Are you seeing a physician at the present time for the treatment of a recent or ongoing medical condition? Y / N
If yes, explain: _____

2. Have you been hospitalized within the last year? Y / N
If yes, explain: _____

3. Have you had a serious illness or operation within the last year? If yes, explain: _____ Y / N

4. Have you ever had any serious medical trouble associated with any dental experience? If yes, explain: Y / N
_____

5. Have you ever been advised to take antibiotics (like penicillin, etc.) before a dental appointment? Y / N
If yes, explain: _____

Do you now or have you had any of the following diseases or problems?

Cardiovascular Disease …… Y / N
If yes, check any that apply:

- O Heart disease
- O Heart murmur
- O Coronary bypass
- O Angina
- O Heart attack
  When? _____
- O Hardening of the arteries
- O High blood pressure
- O Mitral valve prolapse
- O Congestive heart failure
- O Stroke
  When?_____

Rheumatic fever or rheumatic heart disease Y / N
Infective endocarditis Y / N
Congenital heart defects Y / N
Prosthetic (artificial) heart valves Y / N
Pacemaker?
If yes, date of placement _____ Y / N
High cholesterol Y / N
Shortness of breath? Y / N
Do your ankles swell? Y / N
Do you have chest pain upon exertion? Y / N
Abnormal bleeding or extended clotting time Y / N
Frequent or unexpected nose bleeds Y / N
Have you ever required a blood transfusion? Y / N
If yes, what was the date of the transfusion?_____
Are you HIV positive? …… Y / N
Do you have any reason to suspect that you have been exposed to the HIV virus …… Y / N

Hepatitis? …… Y / N
If yes, check type:

- O Type A
- O Type B
- O Type C
- O Other
- O Non-Specific Type
- O Not Sure

Diabetes? …… Y / N
If yes, do you require insulin? Y / N
Type and Dose: _____

Do you have an artificial joint? …… Y / N
If yes, which joint(s)?_____

Have you ever had Tuberculosis (TB)? …… Y / N
Have you ever had a TB test? …… Y / N
Do you have a cough that has lasted more than 3 weeks? …… Y / N
Do you ever cough up blood? …… Y / N
Have you tested positive for Covid-19 …….. Y / N

Cancer? ……..... Y/ N
If yes, type of cancer and date diagnosed _____

Oncologist name _____

Cancer treatments (chemotherapy or radiation & cycle)
_____

Last blood count _____

Central line? …….. …… Y / N

CHECK ANY THAT APPLY:

- O Heart Disease
- O Heart Failure
- O Angina
- O Anemia
- O Leukemia
- O Hemophilia
- O Autoimmune Disease
- O Lupus, Sickle Cell Anemia
- O HIV / AIDS
- O Lung Disease
- O Chronic/ Recurring Sinus Problems
- O Persistent cough
- O Emphysema
- O Bronchitis
- O Pneumonia
- O Asthma/ Hay Fever
- O Ulcers
- O Glaucoma
- O Hearing Disorders
- O Cerebral Palsy
- O Immunocompromised
- O Other_____
- O Acid Reflux
- O Jaundice or Liver Disease
- O Kidney Disease
- O Syphilis or Gonorrhea
- O Sexually Transmitted Disease O Arthritis
- O Inflammatory Rheumatism
- O Joint Replacement
- O Osteoporosis
- O Parkinson's Disease
- O Epilepsy or Other Seizures
- O Alzheimer's Disease
- O Paralysis
- O Multiple Sclerosis
- O Organ transplant
- O Depression
- O Anxiety
- O Psychiatric Treatment
- O Thyroid Disease (Hypothyroidism, Hyperthyroidism)
- O Ulcers
- O Cortisone treatment

When was your last complete physical exam with your medical doctor, including blood tests?

_____

If you are <u>currently</u> taking these medications – prescribed, over-the-counter, herbal. Please list name of drug, dose and frequency.

Antibiotics	Y / N
Antidepressants (Prozac, Zoloft, etc.)	Y / N
Antihistamines	Y / N
Blood Pressure Medicine	Y / N
Blood Thinners	Y / N
Cortisone (Prednisone, etc.)	Y / N
Cholesterol Medication	Y / N
Decongestants	Y / N
Diuretics (water pills)	Y / N
Hormones (birth control pills, estrogen)	Y / N
Inhalants (puffer)	Y / N
Insulin	Y / N
Medicine for Heart Problems	Y / N
Muscle Relaxants	Y / N
Nitroglycerine	Y / N
Pain Medicine (Aspirin, Advil, Tylenol, etc)	Y / N
Prescription Pain Medication	Y / N
Sleeping Pills	Y / N
Thyroid Medicine	Y / N
Tranquilizers	Y / N
Vitamins	Y / N
CBD	Y / N

List all names of drugs & dose

_____

_____

_____

_____

_____

Are you <u>ALLERGIC</u> to any of the following medications (do you get hives, a rash, have trouble breathing, etc.):

O Antibiotics (penicillin, tetracycline, etc .)

O Local or topical Dental Anesthetics (novacaine)

O Codeine

O Aspirin

O Barbituates or Sedatives

O Tranquilizers

O Food (Dairy)

O Cortisone (Steroids)

O Latex

O Other _____

Do you now or have you ever smoked? Y / N
(Please circle) Cigarettes Pipe Cigar Vape Other
If you currently smoke, how many/much per day?_____
If you have smoked in the past but no longer smoke, when did you quit? _____

Do you smoke marijuana / cannabis use? Y / N
How often? _____

Do you chew tobacco? …….. Y / N
If yes, how often? _____

Do you drink alcohol? …… Y / N
If yes, how much? _____

Are you currently on hormone replacement therapy? …… Y / N

Have you ever had an adverse reaction like ... nausea, dizziness, or feeling “spacey” with any drug or medication? Y / N

Do you have any disease, condition or problem not previously listed that you feel we should know about? …… Y / N

WOMEN:
Are you currently pregnant? ……. Y / N
Expected delivery date _____

Dental History

Date of last dental/ dental hygiene visit?
_____

What dental conditions concern you at the present time?
_____

What care did you receive at the last dental visit?
_____

How often do you receive dental treatment or dental hygiene care? _____

Do you require complete mouth care or emergency treatment? _____

Are you under the care of a dental specialist? Y/ N
(Orthodontist, Endodontist, Prosthodontist, Periodontist)
Type? _____

Have you ever had a thorough exam of your mouth including a complete set of radiographs (16-20 films) of your jaws and teeth? ……. Y / N
When?_____

Have you had x-rays in the past two years? …….. Y / N

Have you had any dental problems within the last year with your teeth, gums, jaw, chewing? …… Y / N

In order that we may be sensitive to your dental needs, please tell us of any unpleasant experiences you may have had related to oral care. _____
_____

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