RETURN THIS COVER SHEET WITH YOUR MEDICAL HISTORY

Name (Print): _____

DOB: _____

Date Completed: _____

Please complete the following form to the best of your ability prior to your dental appointment. To ensure accuracy, make sure you review each list of medical conditions thoroughly before making your selections. Full and complete disclosure of medical, dental and pharmacological history is expected as part of your care at the college. Bring the form with you to your appointment and give it to your dental provider. They will review the information on this form with you. Be prepared to discuss and add detail to your answers. Your history will then be transcribed into the dental record.

This information is important in order to provide dental care in a safe manner and to assist you in the management of your overall health. As such, information you provide may result in consultation with your physician or recommendations about seeking medical attention.

If you arrive without the form or the form is not filled out, you will be asked to complete a new form prior to your appointment. If you fill out the paperwork at the college, this will delay your care for the day. Depending on your history and conditions, this could result in an additional appointment.

*You may also mail this form back to the college prior to your appointment. Please allow 7-10 days for mailing time.

UNMC College of Dentistry Medical, Pharmacology and Dental History Form

General Questions

What is your impression of your overall health?
○ Excellent ○ Good ○ Fair ○ Poor

Provide your most recent height _____ and weight _____

Are you under the care of a physician? ☐ YES (name) _____ ☐ NO

When was your last physical examination? (month & year) _____

Has there been any change in your general health within the past year? ☐ YES ☐ NO

Have you been hospitalized within the past two (2) years or had any serious illnesses or operations? ☐ YES ☐ NO

Do you take, or been advised by a physician to take, an antibiotic before dental care? ☐ YES ☐ NO

Have you recently had unexplained weight loss or weight gain? ☐ YES ☐ NO

Have you been diagnosed with active tuberculosis or are you currently taking medication for a tuberculosis infection? ☐ YES ☐ NO

Have you recently been exposed to anyone with tuberculosis? ☐ YES ☐ NO

Do you have a persistent cough greater than 3 weeks in duration? ☐ YES ☐ NO

Have you been coughing up blood? ☐ YES ☐ NO

Within the last week have you experienced any of these (check all that apply}?
☐ Fever ☐ Body aches ☐ Runny Nose
☐ Sore Throat ☐ Nausea ☐ Vomiting or diarrhea ☐ Headache

Allergies

Have you experienced a reaction, been diagnosed with, or treated for an allergy to any of the following (describe the reaction)?

☐ Local anesthetics _____
☐ Penicillin _____
☐ Sulfa drugs _____
☐ Other antibiotic(s) _____
☐ Aspirin _____
☐ Codeine or other narcotic _____
☐ Barbiturates or sedatives _____
☐ Latex or rubber _____
☐ Iodine _____
☐ Metals/jewelry _____
☐ Food _____
☐ Hay fever/seasonal allergies _____
☐ Animals _____
☐ Other _____

UNMC College of Dentistry Medical, Pharmacology and Dental History Form

Pharmacology History and Current Medication List

1. Are you taking any over-the-counter (OTC) medications (pills, patches, rinses, creams), vitamins, minerals, herbals, dietary supplements or homeopathic therapies (If so list below)? ☐YES ☐NO

_____

_____

2. Do you recreationally use/take alcohol, prescription medication, street drugs or other substances? ☐YES ☐NO

3. Do you currently have, or been treated for, a chemical or substance dependency? ☐YES ☐NO

4. Have you recently taken (within the past six months), any of the following medications:

Antibiotics or sulfa drugs ☐YES ☐NO
Antihistamines ☐YES ☐NO
Cortisone (steroids) ☐YES ☐NO
Anti-anxiety (anxiolytics) ☐YES ☐NO
Tranquilizers (neuroleptics) ☐YES ☐NO
Medicine for high blood pressure ☐YES ☐NO
Aspirin (ongoing and regular - daily) ☐YES ☐NO
Anticoagulants (blood thinners) ☐YES ☐NO
Heart medication (other, i.e. arrhythmias) ☐YES ☐NO
Nitroglycerin ☐YES ☐NO
Insulin and/or oral hypoglycemic medication ☐YES ☐NO
Bisphosphonate or other anti-resorptive agent *(Prolia, Fosamax, Boniva, Actonel, Reclast, Zometa)* ☐YES ☐NO
Other _____

5. Are you scheduled to start any new medications? _____

In the table below, list **all** your current (regular or/as needed) medications. Include vitamins, herbs, supplements and other over-the-counter (OTC} medications (pills, patches, rinses, creams), that you routinely take. The first line provides an example for you.

Medication	Dosage	Frequency	Reason
Diovan	160 mg	1 daily	High blood pressure

UNMC College of Dentistry Medical, Pharmacology and Dental History Form

Head, Neck, Eyes, Ears, Nose
Have you experienced, been diagnosed or treated for any conditions in the head and neck area as outlined below?

☐YES ☐NO

If yes, indicate below:

- ☐ Nasal obstructions
- ☐ Nose bleeds
- ☐ Loss of sense of smell
- ☐ Visual impairment
- ☐ Wear contacts/corrective lenses
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Head, jaw or neck injury
- ☐ Hearing Impairment
- ☐ Other _____

_____

Respiratory System
Have you experienced, been diagnosed or treated for any lung or breathing conditions as outlined below?

☐YES ☐NO

If yes, indicate below:

- ☐ Smoking history (pack/yrs)

_____

- ☐ Use oxygen
- ☐ Sore throat
- ☐ Snoring
- ☐ Sleep apnea
- ☐ Sinusitis
- ☐ Asthma
- ☐ COPD
  - ○ Emphysema
  - ○ Chronic Bronchitis
  - ○ Other
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Sarcoidosis
- ☐ Undergone or preparing for lung surgery or lung transplant
- ☐ Other _____

_____

Cardiovascular System
Have you experienced, been diagnosed or treated for any heart, circulation or vein conditions as outlined below?

☐YES ☐NO

If yes, indicate below:

- ☐ Family history of heart disease
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Shortness of breath
- ☐ Swelling of ankles
- ☐ Sleep on more than one pillow
- ☐ Palpitations
- ☐ Chest pain - angina
- ☐ Heart murmur
- ☐ Congestive heart failure
- ☐ Heart attack
- ☐ Mitral valve prolapse
- ☐ Infective endocarditis
- ☐ Rheumatic heart disease or fever
- ☐ Congenital heart defect
- ☐ Coronary heart disease
- ☐ Arteriosclerosis
- ☐ Transient ischemic attack
- ☐ Stroke (CVA)
- ☐ Arrhythmia (irregular beat)
- ☐ Pacemaker
- ☐ Implantable defibrillator
- ☐ Undergone or preparing for open heart surgery for heart value, CABG or transplant
- ☐ Other _____

_____

Gastrointestinal System
Have you experienced, been diagnosed or treated for any stomach, digestive or intestinal conditions as outlined below?

☐YES ☐NO

If yes, indicate below:

- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Acid reflux/Regurgitation (GERD)
- ☐ Jaundice
- ☐ Hepatitis
  - ○ Hepatitis A
  - ○ Hepatitis B
  - ○ Hepatitis C
  - ○ Hepatitis D
  - ○ Hepatitis Other
- ☐ Chronic hepatitis
- ☐ Cirrhosis
- ☐ Ulcers
- ☐ Gallstones
- ☐ Crohn's disease
- ☐ Ulcerative colitis
- ☐ Irritable bowel syndrome
- ☐ Undergone or preparing for GI surgery, or liver or small bowel transplant
- ☐ Other _____

_____

Genitourinary System
Have you experienced, been diagnosed or treated for any kidney or bladder conditions as outlined below?

☐YES ☐NO

If yes, indicate below:

- ☐ Frequent urination
- ☐ Difficult urination
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Prostate (enlarged/cancer)
- ☐ Renal failure/insufficiency
- ☐ Renal dialysis - hemodialysis
- ☐ Renal dialysis - peritoneal
- ☐ Undergone or preparing for GU surgery or kidney transplant
- ☐ Other _____

_____

cont. >>

UNMC College of Dentistry Medical, Pharmacology and Dental History Form

Endocrine System
Have you experienced, been diagnosed or treated for any glandular, hormone or steroid based diseases (ex: diabetes) as outlined below?

☐YES ☐NO

If yes, indicate below:

- ☐ Family history of diabetes
- ☐ Frequent urination
- ☐ Increased thirst
- ☐ Dry mouth
- ☐ Thinning, brittle hair
- ☐ Sensitivity to temperature changes
- ☐ Diabetes
  - ○ Type I
  - ○ Type II
  - ○ Gestational
- ☐ Parathyroid problem
- ☐ Hypothyroid
- ☐ Hyperthyroid
- ☐ Adrenal gland disorder
- ☐ Hormonal replacement therapy
- ☐ Steroid therapy (dose, frequency, duration)
- ☐ Other _____

_____

Muscle, Bone, CT and Skin Systems
Have you experienced, been diagnosed or treated for any muscle, bone, joint or skin conditions as outlined below?

☐YES ☐NO

If yes, indicate below:

- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Arthritis - other
- ☐ Osteoporosis
- ☐ Gout
- ☐ Temporomandibular joint disorder
- ☐ Lupus
- ☐ Scleroderma
- ☐ Psoriasis
- ☐ Lichen planus
- ☐ Fibromyalgia
- ☐ Back or neck injury
- ☐ Undergone or preparing for joint replacement
- ☐ Other _____

_____

Neurological System
Have you experienced, been diagnosed or treated for any nerve, brain or mental health conditions as outlined below?

☐YES ☐NO

If yes, indicate below:

- ☐ Tingling or numbness
- ☐ Fainting or dizzy spells
- ☐ Feelings of anxiety
- ☐ Feelings of depression
- ☐ Weakness
- ☐ Migraines
- ☐ Cluster headaches
- ☐ Headaches
- ☐ Trigeminal neuralgia
- ☐ Epilepsy/seizures
- ☐ Neuropathies
- ☐ Multiple sclerosis
- ☐ Parkinson's disease
- ☐ Dementia/Alzheimer's
- ☐ Psychiatric/mental health condition
  - ○ Bipolar/manic depression
  - ○ Eating disorder (anorexia/bulimia)
  - ○ Schizophrenia
  - ○ Depression
  - ○ Post-traumatic stress disorder
  - ○ Obsessive/ compulsive disorder
  - ○ ADD/ADHD
- ☐ Other _____

_____

Blood and Lymphatic Systems
Have you experienced, been diagnosed or treated for any blood conditions as outlined below?

☐YES ☐NO

If yes, indicate below:

- ☐ Abnormal bleeding with previous extractions or surgeries
- ☐ Bruise easily
- ☐ Swollen lymph nodes or glands
- ☐ Anemia
- ☐ Transfusions
- ☐ Thalassemia
- ☐ Sickle cell trait
- ☐ Sickle cell disease
- ☐ Deep vein thrombosis
- ☐ Leukemia
  - ○ Acute lymphocytic
  - ○ Chronic lymphocytic
  - ○ Acute myelogenous
  - ○ Chronic myelogenous
- ☐ Lymphoma
  - ○ Hodgkin's
  - ○ Non-Hodgkin's
- ☐ Multiple myeloma
- ☐ Bleeding disorder
  - ○ Hemophilia
  - ○ Von Willebrand
  - ○ Drug induced
  - ○ Idiopathic Thrombocytopenia
- ☐ Other _____

_____

cont. >>

UNMC College of Dentistry Medical, Pharmacology and Dental History Form

Infectious Disease
Have you experienced, been diagnosed or treated for any infections or immune conditions as outlined below?

☐YES ☐NO

If yes, indicate below:

- ☐ HIV
- ☐ AIDS
- ☐ MRSA
- ☐ Sexually transmitted infection
  - ○ Syphilis
  - ○ Gonorrhea
  - ○ Chlamydia
  - ○ Genital herpes
  - ○ Human papillomavirus
- ☐ Shingles (herpes zoster)
- ☐ Mononucleosis
- ☐ Acute pharyngitis (strep)
- ☐ Childhood diseases (rubella, rubeola, chicken pox, mumps)
- ☐ Use of IV drugs or other recreational drug use
- ☐ Other _____

_____

Oncology History
Are you employed in any situation which exposes you to x-rays or other ionizing radiation?

☐YES ☐NO

Explain _____

_____

_____

Do you have a family history of cancer?

☐YES ☐NO

List type and family relationship:

_____

_____

_____

Have you experienced, been diagnosed or treated for any form of cancer as outlined below?

☐YES ☐NO

If yes, indicate below:

List type of cancer(s)/location(s):

_____

_____

_____

- ☐ Radiation therapy for a growth, tumor or other condition
- ☐ Chemotherapy for a growth, tumor or other condition
- ☐ Surgical removal of a growth, tumor or other condition
- ☐ Immune modulation therapy for a growth, tumor or other condition
- ☐ Other types of therapy

_____

_____

_____

Women's Health
Have you experienced any of these women's health related issues as outlined below?

☐YES ☐NO

If yes, indicate below:

- ☐ Currently pregnant
- ☐ Currently trying to become pregnant
- ☐ Currently nursing
- ☐ Using birth control pills, implanted birth control medications, fertility drugs or hormone replacement
- ☐ Irregular menstrual cycle or conditions
- ☐ Abnormal menstrual flow
- ☐ Menopause
- ☐ Other _____

_____

_____

Do you have any other medical conditions, diseases or conditions not listed above?

If yes, please specify in the space below.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

cont. >>

UNMC College of Dentistry Medical, Pharmacology and Dental History Form

Dental History

1. What is the reason for your visit?

_____

_____

2. Please describe your current dental problem:

_____

_____

3. When was your last dental visit?

_____

4. What was done at that visit?

_____

5. When was your last dental exam?

_____

6. When were your last dental x-rays (radiographs) taken?

_____

7. When was your last dental cleaning (prophy)?

_____

8. Are you currently experiencing dental pain or discomfort? ☐YES ☐NO

9. Are your teeth sensitive to hot, cold, sweets or pressure? ☐YES ☐NO

10. Do you have changes or alterations in taste sensation? ☐YES ☐NO

11. Do have bad breath, metallic taste or unpleasant taste in your mouth? ☐YES ☐NO

12. Is your mouth dry? ☐YES ☐NO

13. Have you ever been diagnosed with any of the following oral conditions?
    - ○ Candida (thrush)
    - ○ Lichen planus
    - ○ Aphthous ulcer (canker sores)
    - ○ Cold sores or fever blisters

14. Are you having any problems eating? ☐YES ☐NO

15. Do you smoke tobacco products like cigarettes, cigars, pipe or hookah? ☐YES ☐NO

16. Do you use smokeless tobacco products - like snuff or dip? ☐YES ☐NO

17. How long ago did you last use ANY tobacco product (smoked or smokeless)?
    - ○ Never
    - ○ Within the last month
    - ○ Within the last year
    - ○ Greater than 5 yrs but less than 10
    - ○ 10 yrs or greater

18. Are you interested in, or have a history of, tobacco cessation treatment? ☐YES ☐NO

19. Do you have sores or ulcers in your mouth? ☐YES ☐NO

20. Do you have any swelling around your mouth or head and neck area? ☐YES ☐NO

21. Do you have headaches, earaches or neck pains? ☐YES ☐NO

22. Have you ever had a serious injury to your mouth or head and neck area? ☐YES ☐NO

23. Do you have any clicking, popping, discomfort or limited opening of your jaw? ☐YES ☐NO

24. Do you clench or grind (brux) your teeth together? ☐YES ☐NO

cont. >>

UNMC College of Dentistry Medical, Pharmacology and Dental History Form

25. Do you participate in any active recreational activities or sports? ☐YES ☐NO

26. Do you have any loose teeth? ☐YES ☐NO

27. Have you lost any teeth other than by extraction? ☐YES ☐NO

28. Have you had any extractions, oral surgery or other head or neck surgery? ☐YES ☐NO

29. Have you been diagnosed with periodontal (gum) disease? ☐YES ☐NO

30. Have you been treated for periodontal (gum) disease? ☐YES ☐NO

31. Do your gums bleed when you brush, floss or otherwise clean your teeth? ☐YES ☐NO

32. Do you have trouble cleaning or caring for your teeth? ☐YES ☐NO

33. Does food or floss catch between your teeth? ☐YES ☐NO

34. Have you ever had a root canal? ☐YES ☐NO

35. Do you have bridges, or wear dentures or partial dentures? ☐YES ☐NO

36. Have you had orthodontic (braces/retainer) treatment? ☐YES ☐NO

37. Have you ever had local anesthetic for dental purposes? ☐YES ☐NO

38. Have you experienced any problems with local anesthetics? ☐YES ☐NO

39. Have you had any problems with previous dental treatment? ☐YES ☐NO

40. Are you unhappy with your smile or the appearance of your teeth? ☐YES ☐NO

41. Are you worried about losing your teeth? ☐YES ☐NO

42. How many times a week do you brush your teeth?

_____

43. How many times a week do you floss your teeth?

_____

44. Do you use anything else to clean your teeth and how often?

_____

45. On a scale from O (low) to 10 (high) rate your fear or anxiety related to your dental care?

_____

46. Please state any additional questions or concerns about your dental care or your dental health:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

[end]