DENTAL/HEALTH HISTORY

FAMILY HEALTHCARE OF HAGERSTOWN

Patient Name: _____ Today's Date: _____

Date of Birth: _____ Date of last dental visit: _____

Former dentist: _____ Reason for visit:_____

DENTAL HISTORY FOR ALL DENTAL PATIENTS:

Have you ever had any of the following:

Bad breath	☐	Yes	☐	No	Grinding/ Clenching teeth	☐	Yes	☐	No
Bleeding/ Swollen/ Tender gums	☐	Yes	☐	No	Loose teeth or broken fillings	☐	Yes	☐	No
Cigarette, pipe, cigar/ E-cig smoking	☐	Yes	☐	No	Sensitivity to cold/hot/sweets	☐	Yes	☐	No
Clicking or popping jaw/ Jaw pain	☐	Yes	☐	No	Sensitivity when biting	☐	Yes	☐	No
Dry mouth	☐	Yes	☐	No					

How often do you floss? Once a day Twice a day Several times a day Never Other

How often do you brush? Once a day Twice a day Several times a day Never Other

HEALTH HISTORY FOR ALL DENTAL PATIENTS:

Physicians Name: _____ Date of last visit: _____

Have you ever had any of the following:

AIDS/HIV	☐	Yes	☐	No	Kidney disease	☐	Yes	☐	No
Anemia	☐	Yes	☐	No	Learning disorders/behavior issues	☐	Yes	☐	No
Arthritis/Rheumatism	☐	Yes	☐	No	Liver disease/Cirrhosis/Jaundice	☐	Yes	☐	No
Artificial heart valves	☐	Yes	☐	No	Low blood pressure	☐	Yes	☐	No
Artificial joints	☐	Yes	☐	No	Measles/mumps/chicken pox	☐	Yes	☐	No
Asthma	☐	Yes	☐	No	Nervous problem	☐	Yes	☐	No
Back problems	☐	Yes	☐	No	Pacemaker	☐	Yes	☐	No
Bleeding disorders	☐	Yes	☐	No	Physical abuse	☐	Yes	☐	No
Cancer	☐	Yes	☐	No	Pneumonia	☐	Yes	☐	No
Chemical dependency	☐	Yes	☐	No	Psychiatric care	☐	Yes	☐	No
Chemotherapy	☐	Yes	☐	No	Radiation treatment	☐	Yes	☐	No
Circulatory problems	☐	Yes	☐	No	Respiratory disease	☐	Yes	☐	No
Congenital heart lesions	☐	Yes	☐	No	Sexually transmitted disease	☐	Yes	☐	No
Cortisone treatments	☐	Yes	☐	No	Shortness of breath	☐	Yes	☐	No
Cough, persistent or bloody	☐	Yes	☐	No	Sinus trouble	☐	Yes	☐	No
Diabetes (type)	☐	Yes	☐	No	Skin rash	☐	Yes	☐	No
Emphysema	☐	Yes	☐	No	Special diet	☐	Yes	☐	No
Do you wear contact lenses?	☐	Yes	☐	No	Stroke	☐	Yes	☐	No
Epilepsy/seizures	☐	Yes	☐	No	Swollen feet or ankles	☐	Yes	☐	No
Fainting/dizziness	☐	Yes	☐	No	Stomach problems/frequent vomiting	☐	Yes	☐	No
Frequent colds or ear infections	☐	Yes	☐	No	Thyroid problems	☐	Yes	☐	No
Glaucoma	☐	Yes	☐	No	Tonsillitis/frequent strep throat	☐	Yes	☐	No
Headaches	☐	Yes	☐	No	Transfusions	☐	Yes	☐	No
Heart conditions/murmur	☐	Yes	☐	No	Tuberculosis	☐	Yes	☐	No
Hepatitis (type)	☐	Yes	☐	No	Tumor or growth on head or neck	☐	Yes	☐	No
Herpes	☐	Yes	☐	No	Ulcer	☐	Yes	☐	No
High blood pressure	☐	Yes	☐	No	Weight loss	☐	Yes	☐	No
Immunological problems	☐	Yes	☐	No	Other _____				

Medications

Please list any medications you are currently taking and the reason you are taking it:

Medication	Reason

Have you used a bisphosphonate medication? (Fosamax, ☐ Yes ☐ No

Allergies

Aspirin	☐	Yes	☐	No	Local Anesthetic	☐	Yes	☐	No
Sleeping pills	☐	Yes	☐	No	Penicillin	☐	Yes	☐	No
Codeine	☐	Yes	☐	No	Sulfa	☐	Yes	☐	No
Iodine	☐	Yes	☐	No	Other:_____	☐	Yes	☐	No
Latex	☐	Yes	☐	No					

HEALTH INFORMATION FOR FEMALE DENTAL PATIENTS ONLY:

Are you pregnant?	☐	Yes	☐	No
Are you nursing?	☐	Yes	☐	No
Are you taking birth control pills?	☐	Yes	☐	No

If yes, due date: _____

ADDITIONAL HEALTH INFORMATION FOR DENTAL PATIENTS AGED 10 YEARS OR YOUNGER:

Is this the child's first visit to the dentist?	☐	Yes	☐	No
Has your child had trauma to teeth, mouth, or face?	☐	Yes	☐	Date: _____
Do you have fluoridated water?	☐	Yes	☐	No

Was your child premature?	☐	Yes	☐	No
Was your child born with any birth defects?	☐	Yes	☐	No
Does your child attend special classes or schools?	☐	Yes	☐	No

Has your child ever been hospitalized?	☐	Yes	☐	No

If yes to any of the above, please explain:

_____ _____

Signature of Patient/ Parent or Guardian (if patient is a minor) Date

_____

Printed Name of Patient/ Parent or Guardian (if patient is a minor)

Walnut Street Community Health Center, Inc. does business as Family Healthcare of Hagerstown (FHH). This health center receives funding through Health and Human Services (HHS) and is a grantee under 42 U.S.C. 254b. FHH has Federal Public Health Services (PHS) deemed status related to certain health or health-related claims under 42 U.S.C. 233(g)-(n). This includes medical malpractice claims for itself and its covered individuals. FHH is a nonprofit organization under section 501(c)3 of the IRS Code. This institution is an equal opportunity provider and employer.

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