Dental Medical History

Preferred Name: ________________________________ Preferred Pronouns: ________________________________

**CIRCLE THE APPROPRIATE ANSWER**

1. Purpose of visit: ____________________________________________________________________________

2. How long has it been since your last dental treatment: ____________________________________________________________________________

3. Are any of your teeth sensitive to: □ Hot □ Cold □ Sweets □ Pressure? If so, which teeth? ____________________________________________________________________________

4. Are you experiencing any pain or discomfort at this time? □ YES □ NO

5. Have you ever had gum treatment or gum surgery? □ YES □ NO

6. Do your gums bleed or hurt? □ YES □ NO

7. Do you have any sores or lumps in or near your mouth? □ YES □ NO

8. Does your jaw pop or click? □ YES □ NO

9. Do you often have headaches, neck aches or shoulder aches? □ YES □ NO

   What time of day? □ Morning □ Night

10. Have you experienced pain or difficulty when chewing? □ YES □ NO

11. Have you experienced difficulty in opening and closing? □ YES □ NO

12. Do you clench or grind your teeth (while awake or asleep)? □ YES □ NO

13. Are you happy with the appearance of your teeth? □ YES □ NO

14. Have you ever had any problems or complications with previous dental treatment? □ YES □ NO

15. How often do you brush your teeth? ____________________________________________________________________________

16. How often do you floss your teeth? ____________________________________________________________________________

17. Physician’s (or medical clinic’s) name? ____________________________________________________________________________

18. When was your last physical exam? ____________________________________________________________________________

19. Are you under the care of a physician? □ YES □ NO

   Since when? ____________________________________________________________________________ Why? ____________________________________________________________________________

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

21. Have you ever had a serious illness or major surgery? □ YES □ NO

   If so, explain: ____________________________________________________________________________

22. Are you allergic to any medications or substances? □ YES □ NO

   If so, explain: ____________________________________________________________________________

23. Do you have other allergies? □ YES □ NO

24. Have you ever had any problems with (or adverse reactions to) penicillin or other antibiotics, sulfa drugs, anesthetics, or other medications? □ YES □ NO

25. Are you sensitive to any metals or latex? □ YES □ NO

26. Are you taking medications? (Include antibiotics). □ YES □ NO

   Please list: ____________________________________________________________________________

27. Are you taking any over the counter medications and/or supplements? □ YES □ NO

   Please list: ____________________________________________________________________________

28. Have you ever taken any prescription weight loss medications? □ YES □ NO

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BOYNTON HEALTH

UNIVERSITY OF MINNESOTA
Dental Medical History (continued)

29. Are you taking any bisphosphonate medications (i.e. Fosamax, Boniva)? □ YES □ NO
30. Are you being or have you been treated for chemical dependency? □ YES □ NO
31. Do you smoke, chew, use snuff or any other forms of tobacco? □ YES □ NO
32. Are you pregnant or do you suspect you may be? □ YES □ NO
   How many weeks / due date: __________________
33. Have you had or do you test positive for hepatitis? □ YES □ NO
34. Have you tested H.I.V. positive? □ YES □ NO
35. Have you ever been treated or been told that you might have a heart condition, heart disease or a heart murmur? □ YES □ NO
36. Do you have a pacemaker, artificial heart valve implant, artificial joints, implants, or prosthesis? □ YES □ NO
37. Do you have or have you ever had any of the following diseases, or conditions? If you answer yes, please indicate when.
   a. prolapsed mitral valve? □ YES □ NO __________
   b. high or low blood pressure? □ YES □ NO __________
   c. stroke? □ YES □ NO __________
   d. asthma or sinus trouble? □ YES □ NO __________
   e. tuberculosis (T.B.)? □ YES □ NO __________
   f. epilepsy or seizure disorder? □ YES □ NO __________
   g. diabetes? □ YES □ NO __________
   h. thyroid problems? □ YES □ NO __________
   i. stomach ulcers? □ YES □ NO __________
   j. eating disorders? □ YES □ NO __________
   k. kidney trouble, transplant or dialysis? □ YES □ NO __________
   l. liver disease or jaundice? □ YES □ NO __________
   m. rheumatic fever, scarlet fever, or rheumatic heart disease? □ YES □ NO __________
   n. inflammatory diseases (arthritis, rheumatism)? □ YES □ NO __________
   o. any sexually transmitted disease? □ YES □ NO __________
   p. if you are 26 years old or younger have you completed the HPV series? □ YES □ NO __________
   q. bled excessively after being cut or injured? □ YES □ NO __________
   r. any blood disorders (anemia, leukemia, etc.)? □ YES □ NO __________
38. Is there anything else we should know about your health that we have not covered in this form? □ YES □ NO ____________________________

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Patient’s signature: ____________________________ Date: __________________________

Provider’s signature: ____________________________ Date: __________________________