

Patient Name: _____ **Date of Birth:** _____

PATIENT HISTORY (PLEASE COMPLETE ALL PAGES)

Your answers on this form will help your healthcare team obtain an accurate history of you or your child's health concerns and conditions. If you cannot remember specific details or if you have questions/concerns about the information we are requesting, please speak with your healthcare team.

Allergies:

Source: (medications, pollens, food, animals, other)	Type of reaction:

Current Medications: (include prescriptions, over the counter, supplements, vitamins, and herbs)

Name of Drug	Dose	Times Per Day	Reason	Prescriber

Health Maintenance:	Yes	No
Dental visit in the past year?		
Vision check in the past year?		
Medical check-up in the past year?		

Hospitalization and Surgical History (include psychiatric):

Reason:	Date	Location	Overnight stay?

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Immunizations: Please check off any vaccinations you have had and list the year if known.

Vaccination:	Year	Vaccination	Year	Vaccination	Year
Flu Shot		Polio		Tetanus	
Hepatitis A		Meningitis		Tetanus w/ Pertussis (DTAP, Tdap)	
Hepatitis B		Covid		Varicella (Chicken Pox) Shot	
HPV		Pneumonia (P13, P23)		H. Influenza	
MMR		Shingles (Shingrix, Zostavax)		Other:	

Have you had any of the following screening tests?

Test Type:	Completed/Obtained		Date	Testing Location	Result (please choose)
Colonoscopy	Yes	No			Abnormal
Dexa (Bone Density) Scan	Yes	No			Abnormal
Heart tests: Catheterization, stress test, echo	Yes	No			Abnormal
Mammogram	Yes	No			Abnormal
Pap	Yes	No			Abnormal
Hepatitis A, B or C (blood test)	Yes	No			Abnormal
HIV/AIDS (blood test)	Yes	No			Abnormal
Herpes Simplex I and II (blood test)	Yes	No			Abnormal

For the following questions, please answer to the best of your ability and/or address with your Provider.

Sexual Activity:

Sexually Active (check box): Yes No Prefer not to discuss

Contraception (include all that apply): Condom, Pill, Diaphragm, Other: _____

Tobacco Use and/or Vaping/E-Cigarettes:

Smoking Status (check one):

Current every day smoker Current someday smoker Former smoker Never smoker

Current Smoker: Pack/Day: _____ Years: _____

Use Details:

Have you attempted to quit (check one): Yes No

Quit date: _____ How many years did you smoke: _____ How many packs/day did you smoke? _____

Other tobacco (please check all that apply) Pipe Cigar Snuff Chew E-Cigarettes

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Past and Current Medical Conditions: Please indicate with an X if you have had the following:

	Skin Condition		Neurology
	Eczema/Psoriasis		Migraine or headaches
	Eyes/Ears		Seizure or fainting spells
	Blindness		Epilepsy
	Hearing Loss		Traumatic Brain Injury/Concussion
	Respiratory		Developmental Delay
	Asthma		Stroke (Date: _____)
	Pneumonia		Musculoskeletal
	Cardiovascular		Back/Neck Injury
	Hypertension		Arthritis
	High Cholesterol		Osteoporosis
	Heart Disease		Urological/Renal
	Heart Attack		Kidney Stones
	Heart Valve Replacement		Chronic Kidney Disease
	Gastrointestinal		Frequent Urinary Tract Infection
	Irritable Bowel/Ulcerative Colitis/Crohn's		Behavioral Health
	Endocrinology		ADHD
	Diabetes Type I		Learning Disability
	Diabetes Type II		Depression
	Thyroid		Anxiety
	Blood Conditions		Substance Use Disorder
	Anemia		Bipolar Disorder
	Bleeding/Clotting Problems		Post Traumatic Stress Disorder
	Cancer		Schizophrenia/Psychosis
	Diagnosis and Date:		Eating Disorder
	Chemotherapy		Other Conditions: (Please Specify)
	Radiation Treatment		

Family History: Please indicate with an X if a family member has one of the following conditions:

Condition	Mother	Father	Siblings	Grandparents
Heart Disease				
High Blood Pressure				
Cancer (Breast, Ovarian, Colon, Prostate)				
Diabetes				
Glaucoma				
Mental Illness				
Stroke				

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Dental information:	Yes	No	Don't Know
Do your gums bleed when you brush or floss?			
Are your teeth sensitive to cold, hot, sweets, or pressure?			
Does food or floss catch between your teeth?			
Is your mouth dry?			
Have you had any specialized periodontal (gum) treatments?			
Have you ever had orthodontic (braces) treatment?			
Have you had any problems associated with previous dental treatment?			
If yes, Explain:			
Are you currently experiencing dental pain or discomfort?			
Do you have earaches or neck pains?			
Do you have any clicking, popping, or discomfort in the jaw?			
Do you grind your teeth?			
Do you have sores, ulcers, or cold sores in your mouth?			
Do you wear dentures or partials?			
Do you have any dexterity issues that lead to challenges with oral hygiene?			
Have you ever had a serious injury to your head or mouth?			
Have you ever taken (previously, currently or planning to take) any medications for osteoporosis, bone pain, hypercalcemia or skeletal complications ? Eg. alendronate (Fosamax), Boniva, risedronate (Actonel) or Denosumabs like Xgeva, Prolia, (Zoledronic Acid (Reclast or Zometa) or pamidronate (Aredia)			
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?			
Are you currently on a ' blood thinner ' such as Warfarin, Coumadin, Xarelto, Plavix/clopidogrel or Aspirin?			
Are you immunocompromised or are you taking any medications that suppress your immune system (e.g. medications after organ transplant, immunosuppressant drugs for cancer etc.?)			