Montgomery County Department of Health & Human Services Dental Program
Patient Dental & Medical Health History Form

Today's Date ___ /___ /___

PATIENT INFORMATION

Last Name: First Name: Middle Name:

Home Phone: Cell Phone: Work Phone:

Email Address:

Mailing Address: City: State: Zip:

Date of Bith (MM/DD/YYYY): __ __/__ __/__ __ __ __

Preferred Language : ☐ English ☐ Spanish ☐ Other: _____

Gender: ☐ Female ☐ Male ☐ Transgender-Identify as Female ☐ Transgender-Identify as Male ☐ Decline to Answer

If you are completing these forms for another person, what is your name and relationship to that person?

Name:_____ Relationship: _____

If executing this form as the patient's personal representative, I represent and warrant that I have full legal right and authority to consent to the performance of any procedure(s) on this patient. If for any reason I no longer have such legal right and authority, I will immediately notify the practice in writing.

DENTAL HISTORY & SYMPTOMS

What is the reason for your visit today?

Are you currently experiencing any dental pain or discomfort? ☐ Yes ☐ No If yes, where?

When was your last dental exam? __ __/__ __/__ __ __ __ When was the last time you had dental x-rays taken? __ __/__ __/__ __ __ __

Please mark an "X" in the box ONLY if it applies to you

Is it hard to open your mouth? ..... ☐

Does it hurt to chew bite or swallow? ..... ☐

Do your gums bleed when you brush or floss your teeth? ..... ☐

Are your teeth sensitive to cold, hot, sweets or pressure? ..... ☐

Have you ever had periodontal (gum) treatments like scaling and root planing? ..... ☐

Do you have, or have you ever had any sores or growths in your mouth? ..... ☐

Do you clench or grind your teeth? ..... ☐

Does your jaw click, pop or hurt? ..... ☐

Do you have earaches, or neck pains? ..... ☐

Do you have problems with eating (trouble chewing, vomiting, etc.)? ..... ☐

Do you have bridges or wear dentures or partials? ..... ☐

Have you ever had a serious injury to your head or mouth? ..... ☐

If yes, please described what happened and when it happened:

_____

_____

Have you ever had problems with dental treatment in the past? ..... ☐

If yes, describe what happened: _____

_____H

ave you ever had a reaction to, or a problem with, dental anesthesia? ..... ☐

If yes, please describe what happened: _____

_____

Does dental treatment make you nervous? ..... ☐

Do you have any obstacles to cleaning or caring for your teeth? ..... ☐

SPECIAL NEEDS

Physical or Mental ☐ Yes ☐ No If care needed, name of the person providing care during the day: _____

Accusations Needed: ☐ Wheelchair access ☐ Translator ☐ Sign language interpreter ☐ Accompanying caregiver

Please use an "X" to mark your answers to the following questions. Yes No ?

Are you taking any **blood thinners** (such as Coumadin, Warfarin, rivaroxaban (Xarelto®), dabigatran (Pradaxa®), clopidogrel (Plavix®), heparin or aspirin)?..... ☐ ☐ ☐

If yes, what medications are you taking? _____

Are you taking medication to treat **osteoporosis** or Paget's disease? Some commonly prescribed drugs include alendronate (Fosamax®), risedronate (Actonel®), ibandronate (Boniva®), zolendronate (Reclast®), and denosumab (Prolia®) ..... ☐ ☐ ☐

If yes, what medications are you taking? _____

Are you taking or scheduled to take, an IV medication to treat bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?..... ☐ ☐ ☐

Some commonly prescribed drugs include denosumab (Xgeva®), pamidronate (Aredia®) or zolendronate (Zolmeta®).

If yes, what medications are you taking? _____

Are you taking **hormonal replacements**?..... ☐ ☐ ☐

Are you taking, have you recently taken (within the last month), or are you supposed to be taking any medications?..... ☐ ☐ ☐

If yes, please specify medication(s), dosage, and frequency. Please include over the counter prescriptions, vitamins, natural, herbal and/or supplements. Please attach a list if additional room needed.

Medication Prescription or Over the Counter	Dosage/Frequency	Medication Prescription or Over the Counter	Dosage/Frequency

Yes No ?

Do you use any form of **tobacco or nicotine products** (cigarettes, cigars, snuff, chew, bidis)?..... ☐ ☐ ☐

If yes, how often is your use? ☐ Daily ☐ Several times per week ☐ Weekly ☐ Occasionally

Do you use **vaping products**?..... ☐ ☐ ☐

How many **alcoholic beverages** do you have per week? _____

Do you use **controlled substances** (drugs) including marijuana, for medicinal or recreational reasons?..... ☐ ☐ ☐

If yes, what substances? _____ If yes, how often is your use? ☐ Daily ☐ Several times per week ☐ Weekly ☐ Occasionally

Was the substance prescribed by a doctor? ☐ Yes ☐ No If yes, for what reason(s)? _____

WOMEN ONLY: Are you taking **birth control pills?** ☐ Yes ☐ No **Pregnant**? If yes, number of weeks: _____ **Nursing**? If yes, number of weeks: _____

ALLERGIES Please use an "X" to mark your answers to the following questions. Are you allergic to or have you had an allergic reaction to:

	Yes	No	?
Aspirin	☐	☐	☐
Barbiturates, sedatives or sleeping pills	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Hay fever/seasonal allergies	☐	☐	☐
Iodine	☐	☐	☐
Latex (rubber)	☐	☐	☐
Local anesthetics	☐	☐	☐
Metals	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐

Yes No ?

Sulfa drugs such as sulfamethoxazole-trimethoprim (Septra, Bactrim), erythromycin-sulfisoxazole, sulfasala-zine (Azulfidine), erythromycin-sulfisoxazole (Eryzole, Pediazole) glyburide (Diabeta, Glynase PresTabs), dapsone, sumatriptan (Imitrex), celecoxib (Celebrex), hydroclorothiazide (Microzide) and furosemide (Lasix)..... ☐ ☐ ☐

Other..... ☐ ☐ ☐

Please describe any "Yes" answers and include information about your experience

_____

_____

MENTAL HEALTH HISTORY

Have you ever received treatment for behavioral health issues? ☐ Yes ☐ No If yes, describe them briefly_____

Do you currently have any behavioral health concerns? ☐ Yes ☐ No If yes, describe them briefly_____

Are you taking any medication for behavioral health? ☐ Yes ☐ No If yes, specify the medication(s) and dosage_____

MEDICAL & SURGICAL HISTORY Please use an "X" to mark your answers to the following questions.

Please use an "X" to mark your answers to the following questions. **Yes No ?**

Are you in good physical health? ☐ ☐ ☐

Are you currently being seen or treated by a physician? ☐ ☐ ☐

Has a physician or previous dentist recommended that you take **antibiotics** before having dental work done? ☐ ☐ ☐

Have you had a **serious illness, operation or been hospitalized** in the past 5 years? ☐ ☐ ☐

Have you had any type (either total or partial) of **joint replacement** surgery (such as for a hip, knee, shoulder, elbow, finger, etc. ☐ ☐ ☐

Have you had a **heart valve replacement or heart surgery**? ☐ ☐ ☐

Have you had an **organ or bone marrow/stem cell transplant**? ☐ ☐ ☐

If you answered yes to any of the above, please explain:_____

IN THE PAST 30 DAYS, HAVE YOU: Please use an "X" to mark your answers to the following questions.

	Yes	No	?
had pain or tightness in the chest?	☐	☐	☐
coughed up blood or had a cough that lasted longer than 3 weeks?	☐	☐	☐
been exposed to anyone with tuberculosis?	☐	☐	☐
had a rapid or irregular heartbeat?	☐	☐	☐
found it hard to catch your breath?	☐	☐	☐
had a high fever (greater than 101.5˚F) for no reason?	☐	☐	☐
noticed a change in your vision?	☐	☐	☐
fainted for no reason?	☐	☐	☐
experienced vomiting, diarrhea, chills, night sweats or bleeding?	☐	☐	☐
had migraines or severe headaches?	☐	☐	☐

Date of last physical exam: __ __ /__ __ /__ __ __ __

Normal blood pressure (systolic/diastolic) ___ /____

Doctor's Name: Phone:

MEDICAL HISTORY SPECIFIC Please use an "X" to mark your answers to the following questions.

Do you have, or have you been diagnosed with, any of the following conditions?

Heart (Cardiac) Health	Yes	No	?
Pacemaker/implanted defibrillator	☐	☐	☐
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Congenital heart disease (CHD)	☐	☐	☐
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Coronary artery disease	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur/rhythm disorder	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Stroke	☐	☐	☐
Breathing (Respiratory) Health			
Asthma (COPD)	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Eye (Vision) Health			
Glaucoma	☐	☐	☐

	Yes	No	?
Cancer	☐	☐	☐
Type: _____			
Date of diagnosis: _____			
Chemotherapy: _____			
Radiation treatment: _____			
Blood (Circulatory) Health			
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____			
Hemophilia	☐	☐	☐
High or low blood pressure	☐	☐	☐
Brain (Neurological)/Mental Health			
Anxiety	☐	☐	☐
Depression	☐	☐	☐
Epilepsy	☐	☐	☐
Mental health disorders	☐	☐	☐
Neurological disorders	☐	☐	☐
Post-traumatic stress disorder	☐	☐	☐
Traumatic brain injury or concussion	☐	☐	☐
Autoimmune Disease			
AIDS or HIV Infection	☐	☐	☐
Date of last CD4/VL test _____			
Lupus	☐	☐	☐

	Yes	No	?
Diabetes	☐	☐	☐
☐ Pre-Diabetes ☐ Type I ☐ Type II ☐ Gestational			
Date of Last A1C test _____			
Result of Last A1C test _____			
Digestive Health			
Gastrointestinal disease	☐	☐	☐
G.E. reflux/persistent heartburn (GERD)..	☐	☐	☐
Stomach ulcers	☐	☐	☐
Other			
Arthritis	☐	☐	☐
Chronic pain	☐	☐	☐
Eating disorder	☐	☐	☐
Frequent infections	☐	☐	☐
Type of infection: _____			
Hepatitis, jaundice or liver disease	☐	☐	☐
Immune deficiency	☐	☐	☐
Kidney problems	☐	☐	☐
Malnutrition	☐	☐	☐
Osteoporosis	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Sexually transmitted infection (STI)	☐	☐	☐
Thyroid problems	☐	☐	☐

Do you have any disease, condition, or problem that's not listed here? If so, please explain._____

I have answered the above questions completely, accurately and to the best of my ability.

Singature of Patient/Legal Guardian: _____ **Date**:_____

FOR COMPLETION BY DENTAL PROVIDER

Office Use Only: ☐ Medical Alert ☐ Premedication ☐ Allergies ☐ Anesthesia Reviewed by:_____ Date:_____