Comprehensive Community Health Centers

GENERAL HEALTH INFORMATION

Patient Name _____ Date_____ CHART/ACCT #_____

Birth Date: _____ Age_____

DENTAL HISTORY

1. Are there other conditions of which we should be aware? Yes ___ No___
   If yes please specify _____
2. Why are you here today? Check-up___ Cleaning___ Toothache___ Other___
3. A) When did you last visit the dentist? _____ B) What treatment was preformed? _____
4. A) Was the treatment completed? _____ B) Did you have a cleaning? _____
5. When were your last x-rays taken? _____
6. Have you ever had prolonged bleeding after an extraction? Yes___ No___ If yes specify _____
7. Have you had problems with past dental treatment? Yes___ No___ if yes specify_____
8. Do you have symptoms near your ears associated with movement of your lower jaw such as clicking, popping, pain, or locking open? Yes___ No___ if yes specify _____
9. Have you ever been diagnosed or treated for TMD(Temporomandibular Joint Dysfunction something called TMJ) Yes___ No___ If yes Specify _____
10. A) Do your gums bleed easily? Yes___ No___ B) Do you feel you have bad breath? Yes__ no__
11. A) Are your teeth sensitive to hot or cold? Yes___ No___ B) would you like your Whiter? Yes___ No ___.
12. Are there cosmetic changes you would like to have done to your teeth? Yes___ No___
    If yes specify_____

Medical History

1. Are you under a doctor's care at this time? Yes___ No ___If yes specify:
   Dr's Name_____ Dr's Phone_____
2. Are you allergic to penicillin, codeine, local anesthetics, tranquilizers or any other drug or medicine? Yes___ No ___
3. Are you taking any medication at this time, including birth control, Bisphosphonates, Phen-Fen?
   Yes___ No ___ if yes specify_____
4. (Women) Are you pregnant at this time? Yes ___ No ___ how many months _____
5. Are there any health problems of which we should be advised? Yes___ No ___
6. Do you have, or have had, any of the following? **Please Circle each individually Yes or No**

Artificial heart valve	Yes	No	Emphysema	Yes	No	Liver problems	Yes	No
AIDS/HIV+	Yes	No	Epilepsy	Yes	No	Low blood pressure	Yes	No
Anemia	Yes	No	Fainting	Yes	No	Lung disease	Yes	No
Angina	Yes	No	Glaucoma	Yes	No	Osteoporosis	Yes	No
Arthritis	Yes	No	Heart Attack	Yes	No	Pacemaker	Yes	No
Asthma	Yes	No	Heart Surgery	Yes	No	Psychiatric care	Yes	No
Bleeding Problems	Yes	No	Heart Murmur	Yes	No	Rheumatic fever	Yes	No
Cancer	Yes	No	Hepatitis	Yes	No	Sinus trouble	Yes	No
Chemo/RAD therapy	Yes	No	High Blood pressure	Yes	No	Smoking tobacco	Yes	No
High Cholesterol	Yes	No	Jaundice	Yes	No	Stroke	Yes	No
Cosmetic Surgery	Yes	No	Joint Prosthesis	Yes	No	Thyroid problems	Yes	No
Diabetes	Yes	No	Kidney disease	Yes	No	Tuberculosis	Yes	No
Dizzy Spells	Yes	No	Latex allergy	Yes	No	Venereal disease	Yes	No
Drug Addiction	Yes	No						

Patient signature _____ **Date** _____

Doctors Signature _____ **Date** _____