CLEVELAND AVENUE DENTAL CENTER
Forsyth County Department of Public Health

DENTAL/ MEDICAL HEALTH HISTORY

Referred By: _____

Patient Identification:

Last_____ First _____M_____

Address: _____

Social Security #_____ DOB: _____/_____/_____ Sex: ○ M ○ F Weight _____

Home: (____) _____ Cell: (_____) _____ Email: _____@_____

Race: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Native Hawaiian or Other Pacific Islander ☐ Other

Emergency Contact_____ Phone: (_____) _____

What is the reason for your dental visit today? _____

How do you feel about your smile? _____

Do you have any of the following diseases or problems?

○ Active Tuberculosis ○ Cough that produces blood○ Persistent cough greater than 3 week duration ○ exposed to anyone with Tuberculosis

**** If you answer yes to any of the 4 items above, please stop and return this form to the receptionist******

Medical Information:

Do you have a Primary Care Doctor? ○ Yes ○ No

Primary Care Doctor Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip_____

Date of last medical appointment _____

	Yes	No
Have you had serious illness, operation or been hospitalized in the past 5 years?		
If yes, _____		
Are you currently taking or have you recently taken any prescriptions or over the counter medications?		
If yes, please list, including all vitamins, natural or herbal preparations and / or dietary supplements:		
Do you use controlled substances (drugs)?		
Do you use tobacco (smoke, snuff and/or chew)?		
If yes, how much per day? _____		
If so, how interested are you in stopping? ○ Very ○ Somewhat ○ Not interested		
Do you drink alcoholic beverages?		
If yes, how much do you typically drink in a week? _____		

Dental Information:	Yes	No
Do your gums bleed when you brush or floss?		
Are your teeth sensitive to cold, hot, sweet or pressure?		
Is your mouth dry?		
Have you had any periodontal (gum) treatment?		
Have you ever had orthodontics (braces) treatment?		
Do you have sores or ulcers in your mouth?		
Do you participate in active recreation activities?		
Do you wear dentures or partials?		
Are you currently experiencing dental pain or discomfort?		
Have you had any problems associated with previous dental treatment?		
Do you have clicking, popping or pain in jaw?		
Do you grind your teeth?		
Do you have earaches or neck pain?		

Do you have or have you had any of the following? (Please check) If you are unsure of how to answer any of the questions below, please ask dental staff for help!

	Yes	No		Yes	No
Abnormal Bleeding			Hemophilia		
HIV or AIDS or do you believe you have been exposed?			Hepatitis, Jaundice, Liver Disease		
Anemia			High Blood Pressure		
Angina			Kidney Problems *		
Arteriosclerosis			Low Blood Pressure		
Arthritis			Mental Health Disorders, Specify _____		
Artificial (prosthetic) heart valve*			Mitral Valve Prolapse *		
Asthma			Neurological Disorders, If yes, specify_____		
Autoimmune Disease			Osteoporosis		
Blood Transfusion If Yes, what date_____			Other congenital heart defects *		
Bronchitis			Pacemaker		
Cancer/Chemotherapy/Radiation			Previous infective endocarditis *		
Cardiovascular Disease			Rheumatic Fever		
Congenital Heart Disease*			Rheumatic heart disease *		
Congestive Heart Failure			Seasonal Allergies		
Damaged Heart Valve*			Severe headaches/migraines		
Diabetes: *Type I Type II (circle)*			Severe or rapid weight loss		
Eating Disorder			Sexually Transmitted disease		
Emphysema			Sinus Troubles		
Epilepsy			Sleep Disorders		
Fainting Spells or Seizures			Stroke		
G.I. Reflux/ persistent heartburn			Systemic lupus erythematosus		
Gastrointestinal Disease			Thyroid Problems --- *High* or *Low (circle)*		
Glaucoma			Tuberculosis		
Heart Attack			Ulcers		
Allergies:			***WOMEN ONLY:***		
Local Anesthetics			Are you pregnant?		
Aspirin			If yes, Number of Weeks_____		
Penicillin or other antibiotics			Are you taking birth control?		
Barbiturates, sedatives or sleeping pills			Are you taking hormone replacements?		
Sulfa drugs			Are you nursing?		
Codeine or other narcotics			***Joint Replacement:***		
Metals Latex (rubber)			Have you had an orthopedic total joint (hip, knee, elbow, and finger) replacement? *		
Iodine			Date:_____		
Other			If yes, have you had any complications?		
If other, please explain_____			_____		
Do you have any disease, condition, or problem not listed above that you think we should know about?			If yes, please explain:		

*Dental Assistants-a "Yes" response in any one of these items may indicate that pre-med may be necessary – the dentist should be consulted immediately to reduce patient wait time.

IMPORTANT! Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment. I certify that I have read and understand the above answers to be true to the best of my knowledge. I am signing below on behalf of myself or the below named minor in my guardianship.

_____ _____

Signature (Patient or guardian if patient is a minor) *Date*

_____ _____

Signature of Dentist *Date*

Notes (for dental staff use only): _____

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