Please answer these questions as best you can. We want to know your special needs so we can give you the best care. Please check the answer that is right for you, “Yes”, “No”, “DK” (Don’t Know.) Your answers are confidential and for our records only. - - - - BLACK OR BLUE PEN ONLY

**Medical Yes No DK**

Has there been a major change to your health within the past year? ......................... □ □ □

If yes, please explain:

Are you under the care of a physician or are you receiving ongoing medical care?........... □ □ □

Name of your physician:

Physician’s Phone Number:

Date of your last medical visit:

**Are you pregnant?**........................ □ □ □

**If Yes, due date:**

**Do you breast feed?** ..................... □ □ □

**Do you have any artificial joints, heart valves?** ........................................ □ □ □

If yes, have you had any complications?

**Have you ever been told you need to be pre-medicated prior to dental treatment?** ……………………………….□ □ □

Have you had surgery, x-ray treatment, or chemotherapy for a tumor, growth, or other condition? ..................................... □ □ □

If yes, please explain:

# Other: Yes No DK

Do you use tobacco?.......................... □ □ □

What? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any CURRENT/PAST history substance abuse? …………………………..…... □ □ □

If yes, please explain:

**Dental Yes No DK**

Are you having any dental discomfort

at this time? ............................................. □ □ □

If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Have you ever had serious trouble with previous dental work? …………………………………………..... □ □ □

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does dental work make you nervous? ........ □ □ □

Have you ever had any abnormal bleeding associated with previous extractions, surgery, or trauma? ................................................... □ □ □

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of your last dental visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you floss your teeth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Medical Information:

### Please check the answer that is right for you, “Yes”, “No”, “DK” (Don’t Know).

**Skin Problems** Yes No DK

Rashes……………………….…….. □ □ □

Mole Changes…………………….□ □ □

History of Skin Cancer……… □ □ □

Comments

**Liver Problems** Yes No DK

Hepatitis A, B, or C □ □ □

Alcoholic Liver Disease □ □ □

Other Liver Disease □ □ □

Jaundice □ □ □

Comments

**Other Problems** Yes No DK

Domestic Abuse □ □ □

Immune System Disorders. □ □ □

Please explain

Venereal Disease □ □ □

AIDS/HIV □ □ □

Kidney or Bladder

Problems □ □ □

Frequent Urinary

Tract Infections □ □ □

Comments

 **Endocrine Problems**

Yes No DK

Diabetes - Type I □ □ □

Diabetes - Type II □ □ □

 Latest HbA1c level …………..

Thyroid Problems □ □ □

Other Gland Problems □ □ □

Comments

**Mental Health Problems** Yes No DK

Depression ………………….…...□ □ □

Anxiety ………………….………… □ □ □

History of Psychiatric

Medications …………………….. □ □ □

Comments

**Neurologic Problems** Yes No DK

Epilepsy/Seizures □ □ □

Chronic Headaches □ □ □

History of Head Injury □ □ □

Numbness of Arms,

Legs, Hands or Feet □ □ □

History of Stroke □ □ □

If yes, when Fainting Spells □ □ □

Comments

**Breathing/Lung Problems**

Yes No DK

Hay Fever □ □ □

Shortness of Breath □ □ □

Persistent Cough □ □ □

Positive Test/Treatment

for Tuberculosis □ □ □

Seasonal Allergies □ □ □

Asthma □ □ □

Emphysema □ □ □

Coughing up Blood □ □ □

Comments

**Stomach Problems** Yes No DK

Stomach Pain □ □ □

Heartburn □ □ □

History of Ulcers □ □ □

Colitis □ □ □

Comments

**Heart** **and** **Circulatory** **Problems**

Yes No DK

Heart Attack □ □ □

If yes, when High Blood Pressure □ □ □

Chest Pain (Angina) □ □ □

Heart Murmurs □ □ □

Artificial Valves □ □ □

Other Heart Problems □ □ □

Comments

**Muscle and Bone Problems**

Yes No DK

Joint/Back Pain …. □ □ □

Osteoporosis/ Osteopenia…. □ □ □

History of osteonecrosis …... □ □ □

History of Broken Bones …. □ □ □

Joint Swelling …. □ □ □

Arthritis …. □ □ □

Comments

Do you have any other disease, condition or problem not listed? please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Blood Problems** Yes No DK

Bleeding Problems □ □ □

Anemia □ □ □

Hemophilia. □ □ □

Are you taking blood

thinners? □ □ □

If yes, recent INR level ……………………………………………….

and the date

Comments

Medications Yes No DK

Are you taking any prescription or over-the-counter medications?............................... □ □ □

Please list all medications you are taking (Please include prescription and non-prescription medications):

Medication:…………..Dosage:………………How Often Taken:………..Reason for Medication:……………………

1.

2.

3.

4.

5.

6.

7.

8.

9.

Allergies Yes No DK

Are you allergic to anything? □ □ □

Please list all allergies including reaction: Allergy to: Reaction:

1.

2.

3.

4.

I understand that, to the best of my knowledge, all the proceeding answers are true and correct. If I ever have any change in my health or medications, I will inform my health care provider immediately. I hereby give my consent to treatment for myself, or the named patient (of whom I am the parent, legal guardian, or foster parent) to the Dakota Dental and wellness Center.

**We set aside time just for you. If you’re running late or must change an appointment, please call us as soon as possible. Arriving late may require your provider to reschedule your visit to allow enough time for your care. If you miss an appointment, you may have to wait for another opening. If you miss two appointments, you may be only able to make same-day appointments. By calling us when you are unable to make your scheduled appointment, we are able to see other patients waiting for an appointment. These rules are firm so that we can serve everyone in need of care.**

Signature of Patient or Guardian: Date

Signature of Hygienist: Date: 🞏 Not Applicable

Signature of Dentist: Date: 🞏 Supervising

 🞏 Treating