NOTCH
Northern Tier Center for Health
Federally Qualified Health Center

Dental History Questionnaire - Adult

Name:_____DOB: _____Today's Date: _____

Reason for your dental visit today? _____

Please answer each of the following questions completely:

Please list any medical treatment you are currently receiving for any reason: _____

_____

Please list any previous hospitalization for surgical procedures or serious illness: _____

_____

Please list any medications or nutritional supplements? (prescribed, over the counter, or illicit) you may be taking:

Medication	Dose/Frequency	Reason	Medication	Dose/Frequency	Reason

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax, Actonel, Ateiva, Boniva, Reclast, Prolia) for osteoporosis or Paget's disease? *Yes* ☐ *No* ☐

Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia, Zometa, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? *Yes* ☐ *No* ☐

	Yes	No
Do you use tobacco or smokeless tobacco?	☐	☐
Do you use alcohol?	☐	☐

	Yes	No
Do you have active Tuberculosis?	☐	☐
Have you been previously diagnosed with Tuberculosis?	☐	☐
Do you have a persistent cough or throat clearing not associated with known illness (lasting more than 3 weeks)?	☐	☐
Do you have a cough that produces blood?	☐	☐

If you Answered YES to the above questions, please stop and return this form to the receptionist.

	Yes	No
Is your home water supply fluoridated?	☐	☐
Do you drink bottled or filtered water?	☐	☐

If yes, how often? *Daily* ☐ *Weekly* ☐ *Occasionally* ☐

Dental History: *Do you currently have, or have you had any of the following? (Check all that apply)*

- ☐ Bleeding gums when brushing / flossing
- ☐ Sensitive teeth (to sweet/sour liquids/foods)
- ☐ Pain in any of your teeth
- ☐ Any head, neck, or jaw injuries
- ☐ Teeth clenching or grinding
- ☐ Dry mouth
- ☐ Earaches or neck pains
- ☐ Dentures or partials
- ☐ Frequently biting of lips/cheeks
- ☐ History of any difficulty extractions
- ☐ Prolonged bleeding after extractions
- ☐ Orthodontic treatment (e.g. braces)
- ☐ Instructions on brushing and flossing
- ☐ Periodontal (gum) treatments
- ☐ Sores or ulcers in your mouth
- ☐ Participate in recreational activities

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☐ Any jaw problems (e.g. clicking or pain – joint, ear, side of face etc.)
☐ Difficulties with any dental treatment - *explain:*_____

Date of your last dental exam: _____ Date of your last dental x-rays: _____

What was done at that time? _____

Allergies: Are you allergic to or have you had any reactions to the following *(check all that apply)*:

☐ Local Anesthetics such as Novocain	☐ Barbiturates	☐ Sedatives
☐ Aspirin	☐ Penicillin	☐ Latex
☐ Iodine	☐ Sulfa Drugs	☐ Animals
☐ Metals	☐ Hay fever/seasonal	☐ Food
☐ Other: _____		

Are you now under the care of a physician? *Yes* ☐ *No* ☐
Primary Care Provider: _____ Phone: _____ Last Physical Exam: _____

Medical History: *Do you currently have, or have you ever had any of the following? (Check all that apply)*

☐ High / Low Blood Pressure	☐ Heart Disease	☐ Heart Attack
☐ Cardiac Pacemaker	☐ Heart Murmur	☐ Rheumatic Fever
☐ Artificial Heart Valve	☐ Angina	☐ Thyroid Problem
☐ Kidney Disease	☐ Hepatitis	☐ Jaundice
☐ Hay Fever / Allergies	☐ Asthma	☐ Swollen Ankles
☐ COPD / Emphysema	☐ Anemia	☐ Diabetes
☐ Joint Replacement / Implant	☐ Arthritis	☐ Frequently Tired
☐ Fainting / Seizures	☐ Epilepsy	☐ Stroke
☐ AIDS or HIV Infection	☐ Glaucoma	☐ Recent Weight Loss
☐ Sexually Transmitted Disease	☐ Cancer	☐ Stomach Troubles / Ulcers
☐ Leukemia	☐ Liver Disease	☐ Behavioral/Psychiatric Problems
☐ Tuberculosis	☐ Other:	

Women Only – are you: *(Check all that apply)***:**

☐ Pregnant, or may be pregnant	☐ Nursing	☐ On Birth control

I understand that, to the best of my knowledge, all of 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 Northern Tier Center for Health.

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. By calling us when you are unable to make your scheduled appointment, we are able to see other patients waiting for an appointment.

_____ _____
Signature of Patient or Guardian Date