



# Dental History Questionnaire - Adult

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_ Phone: \_\_\_\_\_ Last Physical Exam: \_\_\_\_\_

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

Do you use tobacco or smokeless tobacco?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a persistent cough or throat clearing not associated with known illness (lasting more than 3 weeks)?	<input type="checkbox"/>	<input type="checkbox"/>

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

- |   |                                       |                                    |
|---|---------------------------------------|------------------------------------|
| <input type="checkbox"/> Local Anesthetics such as Novocain | <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Sedatives |
| <input type="checkbox"/> Aspirin                            | <input type="checkbox"/> Penicillin   | <input type="checkbox"/> Latex     |
| <input type="checkbox"/> Peanuts                            | <input type="checkbox"/> Red Dye      | <input type="checkbox"/> Shellfish |
| <input type="checkbox"/> Iodine                             | <input type="checkbox"/> Sulfa Drugs  |                                    |
| <input type="checkbox"/> Other: _____                       |                                       |                                    |

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

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

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

- |   |                                  |   |
|---|----------------------------------|---|
| <input type="checkbox"/> Pregnant, or may be pregnant | <input type="checkbox"/> Nursing | <input type="checkbox"/> On Birth control |
|---|----------------------------------|---|



## Dental History Questionnaire - Adult

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

- |  |  |
|--|--|
| <input type="checkbox"/> Bleeding gums when brushing / flossing                                    | <input type="checkbox"/> Frequently biting of lips/cheeks      |
| <input type="checkbox"/> Sensitive teeth (to sweet/sour liquids/foods)                             | <input type="checkbox"/> History of any difficulty extractions |
| <input type="checkbox"/> Pain in any of your teeth   | <input type="checkbox"/> Prolonged bleeding after extractions  |
| <input type="checkbox"/> Any head, neck, or jaw injuries   | <input type="checkbox"/> Orthodontic treatment (e.g. braces)   |
| <input type="checkbox"/> Teeth clenching or grinding   | <input type="checkbox"/> Instructions on brushing and flossing |
| <input type="checkbox"/> Any jaw problems (e.g., clicking or pain – joint, ear, side of face etc.) |  |
| <input type="checkbox"/> Difficulties with any dental treatment                                    |  |

Explain: \_\_\_\_\_

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