**Mobile Dental Clinic**



 **Medical/Dental History Form**

Patient Name: \_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_\_ Male: \_\_\_\_ Female: \_\_\_\_\_

**Medical History**

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Physician Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1) Have you been under the care of a physician within the past 2 yrs.? Yes No

2) Have you had any serious illness, surgeries or been hospitalized? Yes No

 If yes, reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3) Please list medications/dose you are taking, including supplements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4) Are you allergic to:

 **□** Penicillin  **□** Latex **□** Others: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **□** Sulfa drugs **□** Codeine

  **□** Antibiotics **□** Local Anesthetics

5) Do you take recreational/illicit drugs? Yes No If yes, how often? \_\_\_\_\_\_\_\_ What do you take: \_\_\_\_\_\_\_\_\_\_\_\_

6) Females: Are you pregnant? Yes No Are you taking oral contraceptives? Yes No

7) Do you use tobacco or smoke? Yes No If yes, how much per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8) Has your physician ever told you to take antibiotics prior to dental appointments? : Yes No

9) Do you require special assistance? Yes No If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10) Have you had or been treated for any of the following conditions? Please check each one if yes:

 **□** High Blood Pressure **□** Cancer **□** Arthritis

  **□** Heart Value Replacement **□** Radiation to head/neck **□** Osteoporosis

 **□** Mitral Valve Prolapse **□** Chemotherapy  **□** Seizures/Epilepsy/Fainting

  **□** Psychiatric Disorder **□** Stroke **□** Depressive Illness

  **□** Asthma **□** Rheumatic Fever **□** Drug Dependence

  **□** Autoimmune Diseases **□** Kidney Disease **□** Lung Disease/Bronchitis

  **□** Tuberculosis **□** Gastric Problems **□** Ulcers/Colitis/GERD

  **□** Prolonged Bleeding **□** Headaches/Migraines **□** HIV/AIDS

 **□** Alcoholism **□** Shortness of Breath **□** Thyroid Problems

 **□** Diabetes: Type I or Type II **□** Blood Disorders **□** Liver Disease

 **□** Pacemaker **□**  Heart Murmur Hepatitis A/B/C

 **□** Prosthetic Joint Replacement **□** Others\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Dental History**

1) What brings you to the dentist at this time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2) When was the last time you saw a dental professional? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3) Are you having any pain or discomfort at this time or recently? Yes No

4) Do you wear dentures? Yes No

5) Do you have any of the following?

 **□** Sore/Bleeding Gums **□** Teeth Grinding or Clenching **□** Cold/Canker Sores

 **□** Broken Tooth/Filling **□** Clicking or Popping Jaw **□** Bad Breath

 **□** Sensitive to Hot/Cold **□** Sensitive to biting/pressure **□** Loose Teeth

 **□** Difficulty opening and closing mouth

6) How frequently do you see a dentist? Every 6 months Every Year As needed Never

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

8) How often do you floss? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9) What would you change about your teeth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that the above information is necessary to provide dental care in a safe and efficient manner. The above information is accurate and complete to the best of my knowledge. I will not hold Northwest Community Healthcare, the dentist or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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*Do not write below line- to be completed at Clinic*

Blood Pressure\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pulse\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dr. Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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