Southside Community Health Services

Dental Clinic

Last Name	First Name	Middle Name	Sex (Circle one): Male or Female	Date of Birth / /

When did you last visit your doctor for a regular checkup? ___________________________

Physician/Clinic___________________________________Address___________________________

Check ☑ "Yes" or "No" for any of the following

Yes or No

❑ or ❑ **Heart Disease/Problems**

If yes:

❑ Heart Replacement ❑ Valve Damage
❑ Pacemaker ❑ Valve Replacement
❑ Rheumatic Fever w/ Heart Damage
❑ Previous history of Endocarditis
❑ Congenitial unrepaired heart valve

❑ or ❑ **Stroke** When?___________

❑ or ❑ **High Blood Pressure**

❑ or ❑ **Epilepsy or Seizures** Last seizure? _______

❑ or ❑ **Diabetes** ❑Insulin Glucose_______
❑Oral meds A1C_______

❑ or ❑ **Asthma** Last attack? _________

❑ or ❑ **Kidney/Bladder Trouble** Dialysis**?**_____

❑ or ❑ **Thyroid Disease** __________

❑ or ❑ **Tuberculosis / Positive TB test**
❑ Medications taken? How Long?_______

❑ or ❑ **Liver Disease** __________

❑ or ❑ **Arthritis**
Rheumatoid arthritis effecting the heart?______

❑ or ❑ **Have you ever taken Bisphosphonates**?
When? _______

❑ or ❑ **Artificial Joint**
What joint?_________________
Date Placed _____ / _____ / _____

Yes or No

❑ or ❑ **Cancer or Tumor** When? _____________

❑ or ❑ **Radiation Treatment**? What was radiated?_________

❑ or ❑ **Hepatitis (A,B,C) or Jaundice** Which? ___

❑ or ❑ **HIV or AIDS**

❑ or ❑ **Sexually Transmitted Infections** (syphilis, gonorrhea, herpes etc.) Which? ________

❑ or ❑ **Persistent Cough, Cough up Blood**

❑ or ❑ **Anxiety or Depression** _______________
Receiving treatment/controlled? _________

❑ or ❑ **Psychiatric Treatment** Diagnosis? ______

❑ or ❑ **Alcohol or Drug Abuse/Addiction**
Which? ________

❑ or ❑ **Anemia**

❑ or ❑ **Acid Reflux or Eating Disorder** ________

❑ or ❑ **COPD/Emphysema/Lung disease** _______

❑ or ❑ **Glaucoma or Eye Disease**

❑ or ❑ **Blood Disorders** ____________ INR? ____

❑ or ❑ **Ulcers or Stomach Disease** __________

❑ or ❑ **Autoimmune Disorder/Lupus?** _________

❑ or ❑ (Ages 9-26 only): **Received the HPV vaccination?**

❑ or ❑ **Chronic Pain**? ___________

❑ or ❑ On a **blood thinner/experienced excessive bleeding**?__________

❑ or ❑ Have you ever been **hospitalized**? What for?:_______________

❑ or ❑ **Any disease or condition not listed**?_______________________

Are you allergic to any medications, or latex?
Yes☐or NO☐ __________
____

Women only:

❑ or ❑ **Are you pregnant**? Due Date:_____ / _____ / _____

Medications (please list)

__________ __________ __________ __________ __________
__________ __________ __________ __________ __________

A parent or guardian must sign for under 18 years old

Patient/Guardian Signature______________________ Date __/__/____ DDS/DH Signature __________

Updated______________________ Date __/__/____ __________

12/11/2019

⬩ Dental Clinic ⬩
Dental History Form

Are you having problems now? ____

When was your last cleaning? ____

When was your last x-rays or dental treatment? ______________________________

With what dentist? ____

Did you have 18 small x-rays or a panorex? **Yes☐or NO☐** If Yes When? __________________

Do you have any of the following?

- ❑ Toothaches
- ❑ Bad Breath
- ❑ Bleeding Gums
- ❑ Cold Sores
- ❑ Canker Sores
- ❑ Clenching/Grinding teeth
- ❑ Clicking or popping jaw
- ❑ Jaw locked open or closed
- ❑ Periodontal or gum treatment
- ❑ Sensitive teeth

Yes or No

❑ or ❑ Do you smoke or use tobacco? How often? ______________________________

❑ or ❑ Do you put your child to bed with a bottle? What is in it? ____________________

❑ or ❑ Do your children ONLY drink bottled water?