UMKC Dental Faculty Practice

650 E. 25th Street | Suite 277 • Kansas City, MO 64108-2784 (816)235-2121

Medical and Dental History

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ * _____ * ____ _____
Last First MI Preferred Name

Title: _____ **Gender:*** ◯ Male ◯ Female **Family Status:*** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date:* _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ * _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ * _____
Address 1 Address 2

_____ * _____ * _____-____ *
City State Zip Code

Emergency Contact (Name, relationship and phone number): *

_____

_____

What is your occupation? If you are retired, please list your occupation(s) prior to retirement:

_____

_____

Referred to Our Practice From:

_____

_____

Dental Information

Do your gums bleed when you brush or floss? * ◯ Yes ◯ No

Are your teeth sensitive to cold, hot, sweets or pressure? * ◯ Yes ◯ No

Is your mouth dry? * ◯ Yes ◯ No

Have you had any periodontal (gum) treatments? * ◯ Yes ◯ No

Have you ever had any orthodontic treatment (braces)? * ◯ Yes ◯ No

Is your home water supply fluoridated? * ◯ Yes ◯ No

Do you drink mostly bottled or filtered water? * ◯ Yes ◯ No

Are you currently experiencing any dental pain or comfort? * ◯ Yes ◯ No

Do you have earaches or neck pains? * ◯ Yes ◯ No

Do you have clicking, popping or discomfort in the jaw? * ◯ Yes ◯ No

Do you brux or grind your teeth? * ◯ Yes ◯ No

Do you have sores or ulcers in your mouth? * ◯ Yes ◯ No

Do you wear dentures or partials? * ◯ Yes ◯ No

Do you participate in active recreational activities? * ◯ Yes ◯ No

Have you ever had a serious injury to your head or mouth? * ◯ Yes ◯ No

Date and reason for your last dental visit: * _____

Evaluation of past dental experience: *

◯ Excellent ◯ Average ◯ Poor

Date of last dental x-rays * _____

What is the reason for your dental visit today? *

_____

_____

How do you feel about your smile? *

_____

_____

Medical Information

Are you now under the care of a physician? * ◯ Yes ◯ No

Please list the Name, Address, and Phone Number of your current physician(s):

_____

_____

Please provide the Name and Phone Number of your preferred Pharmacy:

_____

_____

Are you in good health? * ◯ Yes ◯ No

Has there been any change in your general health in the past year? * ◯ Yes ◯ No

If yes, what condition is being treated? *

_____

_____

Date of last physical exam: _____

Have you had a serious illness, operation or been hospitalized in the past 5 years? * ◯ Yes ◯ No

If yes, what was the illness or problem? *

Height _____

Weight _____

Are you taking or have you taken any prescription or over the counter medicine(s)? * ◯ Yes ◯ No

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements including the reason for taking:

Joint Replacement

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? * ◯ Yes ◯ No

Date: _____

If yes, have you had any complications? _____

VISIT: http://www.orthoguidelines.org/go/auc/default.cfm?auc_id=224995&actionxm=Terms

Do you wear contact lenses? * ◯ Yes ◯ No

Are you taking or scheduled to begin taking an antireporptive agent (i.eActonel, Aredia, Atelvia, Boniva, Fosamax, Reclast, Prolia, Zometa, XGEVA) for osteoporosis, bone pain, hypercalcemia, or skeletal complications from Paget's Disease, multiple myeloma or metastatic cancer? *

☐ None ☐ IV ☐ Oral ☐ IV and Oral ☐ Taking Currently ☐ Not Taking Currently

Do you use controlled substances (drugs)? * ◯ Yes ◯ No

Do you use tobacco (smoking, snuff, chew, bidis)? * ◯ Yes ◯ No

If so, how interested are you in stopping?

◯ Very ◯ Somewhat ◯ Not interested

Do you drink alcoholic beverages? * ◯ Yes ◯ No

If yes, how much alcohol did you drink in the last 24 hours? _____

If yes, how much do you typically drink in a week? _____

Women Only- Are you:

Pregnant? ◯ Yes ◯ No

Number of weeks: _____

Taking birth control or hormonal replacement? ◯ Yes ◯ No

Nursing? ◯ Yes ◯ No

Allergies

Are you allergic to or have you had a reaction to:

Local anesthetic * ◯ Yes ◯ No

Aspirin * ◯ Yes ◯ No

Penicillin or other antibiotic * ◯ Yes ◯ No

Barbiturates, sedatives or sleeping pills * ◯ Yes ◯ No

Sulfa Drugs * ◯ Yes ◯ No

Codeine or other narcotics * ◯ Yes ◯ No

Metals * ◯ Yes ◯ No

Latex (rubber) * ◯ Yes ◯ No

Iodine * ◯ Yes ◯ No

Hay fever/seasonal * ◯ Yes ◯ No

Animals * ◯ Yes ◯ No

Food * ◯ Yes ◯ No

Other * ◯ Yes ◯ No

Please specify the type of reaction to any allergy:

_____

_____

Please mark yes/no to indicate if you have or have not had any of the following diseases or problems.

Artificial (prosthetic) heart valve * ◯ Yes ◯ No

Previous infective endocarditis * ◯ Yes ◯ No

Damaged valves in transplanted heart * ◯ Yes ◯ No

Congenital Heart Disease (CHD)

Unrepaired, cyanotic CHD * ◯ Yes ◯ No

Repaired (completely) in the last 6 months * ◯ Yes ◯ No

Repaired CHD with residual defects * ◯ Yes ◯ No

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

Please mark yes/no to indicate if you have or have not had any of the following diseases or problems.

Cardiovascular Disease * ◯ Yes ◯ No

Angina * ◯ Yes ◯ No

Arteriosclerosis * ◯ Yes ◯ No

Congestive Heart Failure * ◯ Yes ◯ No

Damaged Heart Valves * ◯ Yes ◯ No

Heart Attack * ◯ Yes ◯ No

Heart Murmur * ◯ Yes ◯ No

Low Blood Pressure * ◯ Yes ◯ No

High Blood Pressure * ◯ Yes ◯ No

Other congenital heart defects * ◯ Yes ◯ No

Mitral Valve Prolapse * ◯ Yes ◯ No

Pacemaker * ◯ Yes ◯ No

Rheumatic Fever * ◯ Yes ◯ No

Rheumatic Heart Disease * ◯ Yes ◯ No

Abnormal Bleeding * ◯ Yes ◯ No

Anemia * ◯ Yes ◯ No

Blood Transfusion * ◯ Yes ◯ No

If yes, date: _____

Hemophilia * ◯ Yes ◯ No

AIDS or HIV infection * ◯ Yes ◯ No

Arthritis * ◯ Yes ◯ No

Autoimmune disease * ◯ Yes ◯ No

Rheumatoid Athritis * ◯ Yes ◯ No

Systemic lupus erythematosus * ◯ Yes ◯ No

Asthma * ◯ Yes ◯ No

Bronchitis * ◯ Yes ◯ No

Emphysema * ◯ Yes ◯ No

Sinus Trouble * ◯ Yes ◯ No

Tuberculosis * ◯ Yes ◯ No

Cancer/Chemotherapy/Radiation Treatment * ◯ Yes ◯ No

Chest pain upon exertion * ◯ Yes ◯ No

Chronic Pain * ◯ Yes ◯ No

Diabetes Type I or II * ◯ Yes ◯ No

Eating Disorder * ◯ Yes ◯ No

Malnutrition * ◯ Yes ◯ No

Gastrointestinal Disease * ◯ Yes ◯ No

G.E. Reflux/persistent heartburn * ◯ Yes ◯ No

Ulcers * ◯ Yes ◯ No

Thyroid Problem * ◯ Yes ◯ No

Stroke * ◯ Yes ◯ No

Glaucoma * ◯ Yes ◯ No

Hepatitis, jaundice, or liver disease * ◯ Yes ◯ No

Epilepsy * ◯ Yes ◯ No

Fainting spells or seizures * ◯ Yes ◯ No

Neurological disorders * ◯ Yes ◯ No

If yes, specify:

_____

_____

Sleep disorder * ◯ Yes ◯ No

Do you snore? * ◯ Yes ◯ No

Mental Health Disorder * ◯ Yes ◯ No

If yes, specify:

_____

_____

Recurrent infections * ◯ Yes ◯ No

Type of infection: _____

Kidney problems * ◯ Yes ◯ No

Night sweats * ◯ Yes ◯ No

Osteoporosis * ◯ Yes ◯ No

Persistent swollen glands in neck * ◯ Yes ◯ No

Severe headaches/migraines * ◯ Yes ◯ No

Severe or rapid weight loss * ◯ Yes ◯ No

Sexually transmitted disease * ◯ Yes ◯ No

Excessive urination * ◯ Yes ◯ No

Has a physician or dentist recommended that you take antibiotics prior to your dental treatment? * ◯ Yes ◯ No

Name of physician or dentist making recommendation:

_____

_____

Phone: include area code _____

Do you have any disease, condition, or problem not listed above that you think I should know about?

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist(s) and their staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of their staff, responsible for any action they take or do not take because of errors or omission that I may have made in the completion of this form.
Signature of Patient/Legal Guardian:

Signature _____ **Date** _____

Signature of Dentist:

Signature _____ **Date** _____

FOR COMPLETION BY DENTIST

Comments:

Response Date: _____