**Medical History**

**REGIS DENTAL CENTER MEDICAL HISTORY AND PATIENT INFORMATION**

Patient Name: DOB: Date:

Address: City: State: Zip:

Phone: H ( ) W ( ) Sex/Gender: \_\_\_\_\_\_\_\_

Cell ( ) Email: Referred by:

Place of Employment/Occupation: /

Emergency contact: Name Relationship

Address Phone ( )

Current/Previous Dentist: Name

Address: Phone ( )

Do you have Dental Insurance? **□ Yes □ No** Do you have MassHealth? **□ Yes □ No**

**GENERAL MEDICAL INFORMATION**

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| 1. Please rate your health □ Excellent □ Very Good □ Good □ Fair □ Poor 2. Has there been any change (illnesses, allergies, medications, hospitalizations) in your general health in the past year? □ Yes □ No   If yes, please explain   1. Name of physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address/City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. Date of last examination (Month/Year):\_\_\_\_\_\_\_Phone ( ) 3. Currently under treatment by a physician? □ Yes □ No   If yes, please explain   1. **Do you need to take antibiotics prior to receiving dental or surgical care?** □ Yes □ No 2. Do you feel safe at home? **□ Yes □ No** |

**MAJOR HOSPITALIZATIONS, SURGERIES AND BLOOD TRANSFUSION** □ **Mark here if none**

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| --- |
| 1. Date (Month/Year) Reason |

**ALLERGIC OR UNUSUAL REACTION TO ANY OF THE FOLLOWING** □ **Mark here if none**

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| 1. □ **Penicillins** □ **Opiates/codeine** □ **Bisulfite/Sulfite agents**   □ **Sulfa** □ **Iodine** □ **Latex** □ **Other drugs:**    **Type of reaction**    □ Other substances (food, metals, etc…) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**PRESCRIPTION/NON-PRESCRIPTION MEDICATIONS** □ **Mark here if none**

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| 1. List all medications and herbal supplements that you are currently taking.   Name For what condition? Dose/Frequency of use  a)  b)  c)  d)  e)  f) |

**SMOKING HISTORY** □ **Mark here if never**

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| 1. Do you currently smoke? □ Yes □ No   If yes, which of the following do you smoke?  □ Cigarettes □ cigars □ pipe □ other How often?   1. Have you ever smoked? □ Yes □ No If yes, how long? Stopped smoking When?\_\_\_ 2. Do you currently use chew tobacco? □ Yes □ No If yes, how often? |

**WOMEN ONLY** □ **Not applicable**

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| 1. Are you:   □ **Pregnant?**  weeks □ Trying to become pregnant? □ Not sure if you are pregnant?  □ Nursing  □ Using birth control pills Name  □ Going through menopause |

**LOCAL ANESTHESIA**

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| 1. Have you ever had any reactions or problems with local anesthesia? □ Yes □ No   If yes (please explain) |

**DENTAL HISTORY**

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| --- |
| 1. Date of last dental cleaning (Month/Year): 2. Date of last radiograph (Month/Year): 3. Current sensitivity? □ Yes □ No   Hot/Cold □ Yes □ No Chewing □ Yes □ No Air □ Yes □ No  Length of time Area: □Upper Left □Upper Right □Lower Left □Lower Right   1. Dental Implants? □ Yes □ No 2. Family history of gum/periodontal disease? □ Yes □ No 3. Do you clench/grind? □ Yes □ No |

**PAST/CURRENT MEDICAL CONDITION** Patient Initials DOB

1. **Mark symptoms that you have now or have recently experienced.** □ **Mark here if none**

|  |  |
| --- | --- |
| **GENERAL**  □ Bruise easily □ Bleed easily  □ Faint easily □ Anxious  □ Other  **HEART AND BLOOD CONDITIONS**  □ Blood pressure  □ Heart disease  □ Heart attack  □ Heart surgery  □ Valve replacement  □ Pacemaker  □ Heart murmur  □ Bleeding disorder  □ Anemia  □ Hemophilia  □ Other  **RESPIRATORY**  □ Asthma □ Emphysema  □ Tuberculosis □ Pneumonia  □ Sleep Apnea □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_  **NEUROLOGICAL**  □ Stroke □ Seizures  □ Epilepsy □ Convulsions  □ Paralysis □ Memory changes  □ Other  **MUSCULOSKELETAL**  □ Arthritis □ Joint pain or swelling  □ Osteoporosis □ Paget’s disease  □ Joint replacement □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_  **HEAD & NECK**  □ Jaw pain □ Neck pain □ Other  □ Facial pain □ Headache □ Teeth  □ Neck swelling □ Plastic surgery (cosmetic) | **SOCIAL**  □ Drink alcoholic beverages  □ Use recreational drugs  □ Other  **IMMUNE**  □ HIV/AIDS  □ Rheumatoid arthritis  □ Lupus erythematosus  □ Sjogren’s Syndrome  □ Other  **HORMONE**  □ Diabetes Type  □ Thyroid Type  □ Adrenal insufficiency  □ Other  **SALIVARY**  □ Sense of too little saliva  □ Sense of too much saliva  □ Mouth feels dry when eating a meal  □ Difficulties swallowing any foods  □ Other  **OTHER**  □ Kidney disease □ Liver disease  □ Organ transplant □ Hepatitis  □ Herpes □ Jaundice  □ Hip, Knee or Joint Replacement  □ Glaucoma □ Port Catheter  □ Disabled □ Infectious endocarditis  □ Shunts/Stents □ HPV Vaccine  □ Cancer – type and treatment      □ Other: |

1. **Is there any disease, condition or problem not listed above that you think we should know about?**

□ **No** □ **Yes (please explain)**

**Patient/Parent Signature** **Date**

Pulse BP Resp Temp ASA Student Faculty