**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**
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**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 usea) 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 □ NoLength of time Area: □Upper Left □Upper Right □Lower Left □Lower Right1. 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