University of Minnesota Dental Clinics

Medical and Dental Questionnaire

Dental Record Number_____

Patient Name (Last, First, MI)

_____

Date of Birth (MM/DD/YYYY)_____

Mark your response to indicate if you have had any of the following diseases or problems.
Mark **don't know (DK)** if you are unsure whether you have had the disease or problem.
If you have a disease or problem that is not listed below, write the disease or condition in the space at the bottom of this form.

	Yes	No	DK
Do you have tuberculosis?	☐	☐	☐
Are you pregnant?	☐	☐	☐

Physician: Name_____Telephone_____

Address:_____

Date of last physical examination: _____

Yes	No	DK	
☐	☐	☐	Any changes in your health within the past year?

Yes	No	DK	**Cardiovascular**
☐	☐	☐	High blood pressure
☐	☐	☐	Angina (chest pain)
☐	☐	☐	Heart attack
☐	☐	☐	Irregular heart beat
☐	☐	☐	Heart surgery
☐	☐	☐	Heart failure
☐	☐	☐	Damaged heart valve
☐	☐	☐	High cholesterol
☐	☐	☐	Heart infection
☐	☐	☐	Stroke

Yes	No	DK	**Hematologic**
☐	☐	☐	Anemia
☐	☐	☐	Sickle cell anemia
☐	☐	☐	Abnormal bleeding

Yes	No	DK	**Respiratory**
☐	☐	☐	Asthma
☐	☐	☐	Emphysema/bronchitis
☐	☐	☐	Sleep apnea
☐	☐	☐	Difficulty breathing

Yes	No	DK	**Endocrine**
☐	☐	☐	Diabetes
☐	☐	☐	Thyroid problem

Yes	No	DK	**Renal**
☐	☐	☐	Kidney disorder
☐	☐	☐	Dialysis

Yes	No	DK	**Immune**
☐	☐	☐	Past use of steroids
☐	☐	☐	Delayed healing

Yes	No	DK	**Musculoskeletal**
☐	☐	☐	Arthritis
☐	☐	☐	Artificial joint
☐	☐	☐	Fibromyalgia
☐	☐	☐	Lupus
☐	☐	☐	Sjogren's Syndrome
☐	☐	☐	Osteoporosis

Yes	No	DK	**Gastrointestinal**
☐	☐	☐	Acid reflux/GERD
☐	☐	☐	Irritable bowel syndrome
☐	☐	☐	Stomach ulcer

Yes	No	DK	**Hepatic**
☐	☐	☐	Liver disease
☐	☐	☐	Jaundice
☐	☐	☐	Hepatitis

Yes	No	DK	**Neurologic**
☐	☐	☐	Epilepsy/seizures
☐	☐	☐	Parkinson's Disease
☐	☐	☐	Multiple sclerosis
☐	☐	☐	Headaches

Yes	No	DK	**Skin**
☐	☐	☐	Hives or skin rash
☐	☐	☐	Other skin lesions

Yes	No	DK	**Eyes/Ears**
☐	☐	☐	Glaucoma
☐	☐	☐	Impaired vision
☐	☐	☐	Impaired hearing

Yes	No	DK	**Mental Health**
☐	☐	☐	Bipolar disorder
☐	☐	☐	Depression
☐	☐	☐	Anxiety
☐	☐	☐	Eating disorders
☐	☐	☐	Sleep disorder
☐	☐	☐	Dementia
☐	☐	☐	Learning disorders

Yes	No	DK	**Infections**
☐	☐	☐	HIV positive/AIDS
☐	☐	☐	Sexually transmitted disease

Yes	No	DK	**Allergies**
☐	☐	☐	Local anesthetic
☐	☐	☐	Antibiotics
☐	☐	☐	Aspirin/ibuprofen
☐	☐	☐	Acetaminophen (Tylenol)
☐	☐	☐	Codeine/narcotics
☐	☐	☐	Metals
☐	☐	☐	Latex
☐	☐	☐	Other:_____

Yes	No	DK	**Other**
☐	☐	☐	Cancer
☐	☐	☐	Cancer treatment
☐	☐	☐	Nursing infant
☐	☐	☐	Tobacco use
☐	☐	☐	Alcohol use
☐	☐	☐	Chemical dependency
☐	☐	☐	Street/recreational/ illicit drug use

Please list any disease, condition, or problem you have that is not listed above.

_____

_____

Please list any hospitalizations or surgeries you have had.

_____

(**Please continue on opposite side**)

Dental Information

Yes	No	
☐	☐	Is it important for you to keep your teeth?
☐	☐	Are you satisfied with the appearance of your teeth?
☐	☐	Are you satisfied with the function of your teeth?
☐	☐	Does food frequently get caught between teeth?
☐	☐	Do your gums often bleed while brushing?
☐	☐	Have you noticed loosening of your teeth?
☐	☐	Have you injured your head, neck, or jaw?
☐	☐	Do you have difficulty eating or swallowing?
☐	☐	Do you have a dry mouth?
☐	☐	Have you had a change in your ability to taste foods?

Yes	No	Problems of the jaw – Have you noticed:
☐	☐	Clicking of the jaw?
☐	☐	Pain (joint, ear, side of face)?
☐	☐	Difficulty opening or closing?
☐	☐	Difficulty chewing?

Yes	No	Oral habits: Do you:
☐	☐	Clench or grind your teeth?
☐	☐	Bite your lips or cheek frequently?

Yes	No	Have you had:
☐	☐	Orthodontic treatment (braces)?
☐	☐	Oral surgery?
☐	☐	Gum treatment?
☐	☐	Your bite adjusted?
☐	☐	A bite plane/guard or other appliance?

Yes	No	Do you currently have:
☐	☐	Dental pain?
☐	☐	Sores or swellings in your mouth?
☐	☐	A partial/full denture or dental implants?
☐	☐	Do you supplement your diet with fluoride?
☐	☐	Have you had any difficulty with dental treatment?

Date of last dental x-rays_____
How often do you brush your teeth? _____
How often do you floss?_____
Date of last dental treatment:_____
Date of last teeth cleaning:_____

Reason for today's dental visit?_____

Please explain if you answered "Yes" to, or are uncertain about, any of the above items.

_____
_____
_____
_____
_____

To the best of my knowledge, the preceding information is complete and correct.

_____ _____
Signature – Patient (or parent/guardian if patient is under 18) **Date**

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MEDICAL UPDATES
I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	PATIENT SIGNATURE	CHANGES TO HEALTH HISTORY	STUDENT INITIALS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Dental Record Number_____
Patient Name (Last, First, MI)
_____
Date of
Birth(MM/DD/YYYY)_____

University of Minnesota School of Dentistry

Medication List

Patient to fill out

Medication & Dose	Condition prescribed for	MM/YYYY started	For use by dentist: Update section (enter date of change & the new dose of medication. If discontinued, enter D/C)		
			Date/Change	Date/Change	Date/Change