Choptank Community Health System, Inc.
Oral Health History Questionnaire

Date: _____

Patient Name: _____ Age: _____ Date of Birth: _____

Social Security Number: _____ Circle One: Male or Female

Primary Care Provider: _____ City/State: _____Phone: _____

Allergies (Patient):
Are you allergic to Latex? YES or NO
Are you allergic to any medications? YES or NO
If yes, please list all medications: _____

Medical History (Patient) ☑ *yes if you have had or currently have any of the following:*

☐ Asthma	☐ Diabetes	☐ Sexually Transmitted Diseases
☐ Angina/Chest Pain	☐ Cancer	☐ HIV/AIDS
☐ Anemia/Blood Disorder/Hemophilia	☐ High Blood Pressure	☐ Kidney Disorder/Dialysis
☐ Easy Bruising or Bleeding	☐ Thyroid Disorder	☐ Liver Problems/Hepatitis
☐ Clotting Disorders	☐ Tuberculosis	☐ Stomach/Bowel Problems
☐ Heart Problems	☐ Vascular Disease	☐ Glaucoma
☐ ADD/ADHD	☐ Epilepsy/Seizures	☐ Spina Bifida
☐ Bipolar Disorder	☐ Arthritis	☐ Stroke
☐ Developmental Problems	☐ Rheumatic Fever	☐ Fainting Spells
☐ Breathing Problems/COPD/Emphysema	☐ Sinus Problems	☐ Joint Replacement

If you answered yes to any of the above questions, please explain:

_____

_____

Have you been hospitalized in the past five years? Circle One: Yes or No **If yes, please give date(s) and reason(s) for hospitalization:**

_____

_____

Family Medical History: ☑ *if yes for immediate family members (i.e. siblings, parents, grandparents)*

☐ Diabetes	☐ Stroke	☐ Vascular Disease
☐ Cancer	☐ Heart Attack	☐ Heart Problems
☐ Anemia/Blood Disorder	☐ High Blood Pressure	☐ Kidney Disorder/Dialysis
☐ Clotting Disorders	☐ Tuberculosis	☐ Bleeding Disorder/Hemophilia

If you answered yes to any of the above questions, please explain:

_____

_____

If you answer yes to the following, please list how often:

Do you (patient) use/smoke/chew tobacco? ☐ Yes ☐ No How Often? _____
Do you regularly use alcohol? ☐ Yes ☐ No How Often? _____
Do you or have you ever used street drugs? ☐ Yes ☐ No How Often? _____

Women:
Are you pregnant, planning to become pregnant or nursing? Please explain:

_____

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LIST MEDICATIONS YOU (PATIENT) CURRENTLY TAKE: ***(include "as needed" and over-the-counter)***

Name of Medication, Dose, Times Per Day	*Name of Medication, Dose, Times Per Day*

DENTAL HISTORY

Why are you here today? _____
Do you have any previous dental records? _____ Date of last visit to the dentist: _____
Reason for the last dental visit: _____
Please answer the following questions:

- Do any of your teeth ache? ☐ Yes ☐ No
- Are your teeth sensitive to hot, cold, sweets or pressure? ☐ Yes ☐ No
- Are any of your teeth loose? ☐ Yes ☐ No
- Are there any sores or growths in your mouth? ☐ Yes ☐ No
- Are you wearing a removable dental appliance (dentures/retainer)? ☐ Yes ☐ No
- Have you ever had orthodontic treatment (braces/retainer)? ☐ Yes ☐ No
- Have you ever had a problem after extraction (bleeding/dry socket)? ☐ Yes ☐ No
- Have you ever had abnormal bleeding? ☐ Yes ☐ No
- Have you ever had an allergic/adverse reaction to dental treatment? ☐ Yes ☐ No
- Have you ever fainted in a dental office? ☐ Yes ☐ No
- Have you ever had to take an antibiotic prior to dental treatment? ☐ Yes ☐ No
- Do you have pain and/or clicking in the jaw joint around your ear? ☐ Yes ☐ No
- Do your gums bleed? ☐ Yes ☐ No
- Do you grind your teeth or clench your jaws? ☐ Yes ☐ No
- Do you have any other dental complaints? ☐ Yes ☐ No

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or a change in medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

Patient/Guardian Signature: _____ Date: _____
Provider Signature: _____ Date: _____