Goodwin
Community Health

Patient name_____ Date of birth_____ Height_____ Weight _____
What is the reason you are seeking dental treatment? _____
If female, are you pregnant? ____, nursing? _____, taking contraceptives? _____

Please read the following and indicate if you have or have had any of the listed conditions and check the appropriate box**, please circle or write in details**.

Yes No

☐☐Heart issues: heart attack, coronary artery disease, endocarditis, heart murmur/defect, pacemaker, artificial heart valves, surgery, other: _____
☐☐Breathing issues: asthma, COPD/emphysema/chronic bronchitis, other: _____
☐☐Tuberculosis or positive TB skin test_____
☐☐Digestive issues: GERD/reflux, Crohn's disease, IBS, ulcers, surgery_____
☐☐Stroke, if yes, when_____
☐☐Immune issues: HIV/ AIDS, auto-immune disorders, other: _____
☐☐Liver issues: hepatitis A, B, C, D, E, cirrhosis, fatty liver disease, other: _____
☐☐Cold Sores (Herpes Simplex I)
☐☐Issue with blood/bleeding/clotting: hemophilia, anemia, factor V leiden, other:_____
☐☐ADHD/ADD
☐☐Thyroid Problem_____
☐☐Current or Past Cancer/Tumor_____
☐☐Artificial Joints
☐☐Fainting
☐☐Diabetes (type I, type II), if yes, what and when was your last HBA1C_____
☐☐Neurological problems: epilepsy/seizures, neuralgia, other:_____
☐☐Mental health issues: anxiety, depression, bi-polar disorder, schizophrenia, other:_____
☐☐Kidney problems: kidney failure, stones, other:_____
☐☐Current or past hx of alcoholism, drug addiction, recreational drug use _____
☐☐Taken Bisphosphonates (Ex. Boniva, Foxamax, Actonel, Atelvia, Reclast etc.)
☐☐Dry mouth
☐☐Disability (physical or mental that may require accommodation) _____
☐☐ Sleep apnea or snoring

Any medical issues not addressed above? _____
Please list all medications, including dosage_____
_____
_____
Allergy or adverse reaction to latex or medications? Please list material or medication and describe reaction (hives, anaphylaxis, GI upset, other :)_____

Do you use tobacco? ___ If yes, how much? _____
If yes, how motivated are you to quit? (please circle) low 1 2 3 4 5 6 7 8 9 10 high
Do you drink alcohol? ___ If yes, about how many drinks per week? _____
Do you drink fruit juice, soda, energy drinks, coffee or tea with sugar regularly? _____
Please tell us about your daily oral hygiene routine_____
For children under 12: What is your source of water? (Municipal, Well, Bottled, If municipal, what town do you live in?_____)

Patient or Guardian signature:_____ Date: _____