

LINCOLN-LANCASTER COUNTY HEALTH DEPARTMENT DENTAL CLINIC



Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Age _____ Date of Birth _____ Height _____ Weight _____ Male Female

Cell Phone _____ Home Phone _____ SS # _____

Place of Employment _____ Work Phone _____

Email Address _____

Spouse's Name _____ Cell Phone _____

Place of Employment _____ Work Phone _____

Person to contact in case of emergency? _____ Phone _____

CHIEF DENTAL COMPLAINT _____

MEDICAL HISTORY

	Yes	No		Yes	No		Yes	No
1) Have you been a patient in a hospital during the past two years?	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>
2) Have you been under the care of a medical doctor during the past two years? If yes, physician's name _____	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Cancer or Tumor	<input type="checkbox"/>	<input type="checkbox"/>
3) Have you had a positive blood or skin test for Tuberculosis? If yes, have you had a chest x-ray since the positive test? Date _____ Results _____	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
4) Do you have active Tuberculosis? Been exposed to anyone with active Tuberculosis? Persistent cough greater than 3 week duration? Cough that produces blood?	<input type="checkbox"/>	<input type="checkbox"/>	Infection In Heart	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
5) Have you ever had any excessive bleeding requiring special treatment?	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>
6) When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are tired?	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever/Allergies	<input type="checkbox"/>	<input type="checkbox"/>
7) Have you had an unexplained loss or gain of more than 10 pounds in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	Heart Birth Defects	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
8) Do you ever wake up from sleep short of breath or sweating heavily?	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
9) Are you on a special diet? Doctor's order or self-imposed?	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains/Angina	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
10) Has your medical doctor ever said you have cancer or a tumor?	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
11) Do you smoke or use smokeless tobacco products such as chewing tobacco? If yes, how much per day? _____	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>
12) Do you drink alcohol? If yes, how many drinks per week? _____	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
13) Do you now use or have used in the past cocaine or other drugs?	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement or Implant	<input type="checkbox"/>	<input type="checkbox"/>
14) Have you been in drug and alcohol treatment? If so, when _____	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Troubles or Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
15) Have you ever taken Phen-Fen or Redux?	<input type="checkbox"/>	<input type="checkbox"/>	Frequently Tired	<input type="checkbox"/>	<input type="checkbox"/>	Fainting/Seizures	<input type="checkbox"/>	<input type="checkbox"/>
			Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>
			Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Mental Health Disorder	<input type="checkbox"/>	<input type="checkbox"/>
			Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>			
			Hepatitis/Jaundice	<input type="checkbox"/>	<input type="checkbox"/>			
			Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>			
			AIDS or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>			
						16) Do you have any disease(s), condition(s), or problems(s) not listed?	<input type="checkbox"/>	<input type="checkbox"/>
						Please list _____		

MEDICATIONS

Are you taking any of the following?	Yes	No
1) Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
2) Sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>
3) Anticoagulants (blood thinners)	<input type="checkbox"/>	<input type="checkbox"/>
4) Medicine for high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
5) Cortisone (steroids)	<input type="checkbox"/>	<input type="checkbox"/>
6) Tranquilizers	<input type="checkbox"/>	<input type="checkbox"/>
7) Antihistamines	<input type="checkbox"/>	<input type="checkbox"/>
8) Antidepressant/Antianxiety Medications	<input type="checkbox"/>	<input type="checkbox"/>
9) Aspirin (regular, ongoing basis)	<input type="checkbox"/>	<input type="checkbox"/>
10) Insulin, Orinase, or similar drug	<input type="checkbox"/>	<input type="checkbox"/>
11) Digitalis or other heart drug	<input type="checkbox"/>	<input type="checkbox"/>
12) Nitroglycerin	<input type="checkbox"/>	<input type="checkbox"/>
13) Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
14) Alcohol/Drugs (chemically dependent)	<input type="checkbox"/>	<input type="checkbox"/>
15) Diet pills	<input type="checkbox"/>	<input type="checkbox"/>
16) Vitamin/herbal supplements	<input type="checkbox"/>	<input type="checkbox"/>
17) Other medications	<input type="checkbox"/>	<input type="checkbox"/>
Comments _____		

ALLERGIES

Are you allergic to or had a reaction to any of the following?

	Yes	No
1) Local anesthetic (novocaine, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
2) Antibiotics _____	<input type="checkbox"/>	<input type="checkbox"/>
3) Sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>
4) Latex	<input type="checkbox"/>	<input type="checkbox"/>
5) Barbituates, sedatives	<input type="checkbox"/>	<input type="checkbox"/>
6) Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
7) Iodine	<input type="checkbox"/>	<input type="checkbox"/>
8) Codeine or other narcotics	<input type="checkbox"/>	<input type="checkbox"/>
9) Metals (rings, earrings, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
10) Other allergies _____	<input type="checkbox"/>	<input type="checkbox"/>

DENTAL HISTORY

	Yes	No
1) Are you having dental pain?	<input type="checkbox"/>	<input type="checkbox"/>
2) Do you think you have gum problems?	<input type="checkbox"/>	<input type="checkbox"/>
3) Do you notice popping, clicking, soreness of the jaw or just in front of your ears?	<input type="checkbox"/>	<input type="checkbox"/>
4) Are you involved in any contact sports?	<input type="checkbox"/>	<input type="checkbox"/>
5) Do you brush daily?	<input type="checkbox"/>	<input type="checkbox"/>
6) Do you floss daily?	<input type="checkbox"/>	<input type="checkbox"/>
7) Have you ever had problems with local anesthetic?	<input type="checkbox"/>	<input type="checkbox"/>
8) Have you ever had any difficult extractions (tooth removal) in the past?	<input type="checkbox"/>	<input type="checkbox"/>
9) Have you ever had prolonged bleeding following extractions (tooth removal)?	<input type="checkbox"/>	<input type="checkbox"/>
10) Do you wear complete or partial dentures?	<input type="checkbox"/>	<input type="checkbox"/>
If so, how many years have you worn dentures?		_____
How old are your present dentures?		_____
11) When was your last dental visit?		_____
12) What was done at your last dental visit?		_____

WOMEN

	Yes	No
1) Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
2) Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>
3) Do you have or have you had menstrual problems?	<input type="checkbox"/>	<input type="checkbox"/>
4) Are you taking birth control pills?	<input type="checkbox"/>	<input type="checkbox"/>
5) Have you been through menopause?	<input type="checkbox"/>	<input type="checkbox"/>

TREATMENT CONSENT

I certify that I have read and understand the above information. To the best of my knowledge, the above answers are true and correct. I understand that providing incorrect information can be dangerous to my health. If I ever have any change in my health, or if my medicines change, I will inform the dental staff at the next appointment without fail. I understand the nature of the clinical services to be rendered including the possible hazards and side effects that may be involved. I understand that alternative methods of treatment may be available and that while all the procedures are considered safe, there is risk of complications or unanticipated results and emergency indications that may prevent the intended beneficial result or require further treatment. I understand that dental services will be rendered by licensed dentists, licensed dental hygienists, or dental and dental hygiene students under the supervision of licensed dentists, and consent to such services. I authorize the Lincoln-Lancaster County Health Department to release any information including the diagnosis of the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners.

Signature _____ Date _____