NAME: _____ DATE: _____ CHART: _____

UNIVERSITY OF WASHINGTON SCHOOL OF DENTISTRY - MEDICAL AND DENTAL HISTORY

GENERAL INFORMATION

1. a. **Date of Birth:** _____ ____ _____ (Month Day Year) b. **Gender:** ○ **Male** ○ **Female** c. **Weight:** _____ lbs.
d. **Height:** _____ ft. _____ inches
e. **Highest grade of regular school that you have completed?** _____ f. **Employed?** ○ Yes ○ No

GENERAL MEDICAL INFORMATION

2. Please rate your health. ○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor
3. Has there been a change in your general health in the past year? ○ Yes ○ No
4. Your Physician:_____City_____ Phone No.: _____
5. Date of last physical examination: Month _____Year _____ Currently under treatment by a physician? ○ Yes ○ No
   Please explain_____
6. Do you engage in regular exercise? ○ Yes ○ No Type_____
7. **Do you need to take antibiotics prior to receiving dental or surgical care? ○ Yes ○ No ○ Don't know**

MAJOR HOSPITALIZATIONS, SURGERIES, AND BLOOD TRANSFUSION → ○ MARK HERE IF NONE ○ VERIFIED BY EXAMINER

8. **DATE (Month/Year)** **REASON**

_____
_____
_____
_____
_____

ALLERGIC OR UNUSUAL REACTION TO ANY OF THE FOLLOWING? → ○ MARK HERE IF NONE ○ VERIFIED BY EXAMINER

9. ○ Penicillins ○ Opiates/codeine ○ Other drugs: ○ Other substances (food, metals, etc.)
   ○ Sulfa drugs ○ Iodine List: 1. _____ List: 1. _____
   ○ Aspirin ○ Latex 2. _____ 2. _____
   ○ Local anesthesia 3. _____ 3. _____

Type of Reaction _____

WOMEN ONLY ——————————→ ○ NOT APPLICABLE

10. **Are you** ○ **PREGNANT?** _____ weeks? ○ Trying to become pregnant? ○ Not sure if you are pregnant?
    ○ Using birth control pills _____ (Name of Prescription) ○ Going through menopause? ○ Post-menopausal?

PRESCRIPTION/ NON PRESCRIPTION MEDICATIONS → ○ MARK HERE IF NONE ○ VERIFIED BY EXAMINER
(Use continuation page if necessary)

11. List all medications and herbal supplements/remedies that you are currently taking.

Name:	For what Condition?	Dose/Frequency of use:
A)		
B)		
C)		
D)		
E)		
F)		

GENERAL MEDICAL INFORMATION - PRESENT SYMPTOMS

12. Mark symptom(s) that you NOW experience or HAVE RECENTLY experienced. → ○ **MARK HERE IF NONE**
○ **VERIFIED BY EXAMINER**

GENERAL
- ○ Weight loss_____ Lbs. Over what time period? _____
- ○ Weight gain_____ Lbs. Over what time period? _____
- ○ Loss of appetite _____
- ○ Always hungry _____
- ○ Always thirsty _____
- ○ Frequent urination_____
- ○ Fatigue _____
- ○ Faint easily _____
- ○ Night sweats_____
- ○ Bleed easily _____
- ○ Bruise easily_____

CARDIOVASCULAR
- ○ Shortness of breath with exertion_____
- ○ Racing or irregular heart beat_____
- ○ Swollen ankles _____
- ○ Cold ankles/feet _____
- ○ Chest pain/angina_____

RESPIRATORY
- ○ Coughing spell_____
- ○ Wheezing_____
- ○ Use 2 or more pillows to sleep_____

MUSCULOSKELETAL
- ○ Joint pain _____
- ○ Swollen joints _____
- ○ Muscle cramping_____

SKIN CHANGES
- ○ Skin problems_____
- ○ Nail changes_____

NEUROLOGICAL
- ○ Numbness/tingling_____
- ○ Paralysis/weakness_____
- ○ Memory changes_____
- ○ Smell/taste changes_____
- ○ Difficulty chewing_____
- ○ Swallowing changes_____
- ○ Speech changes_____
- ○ Dizzy spells or fainting_____

GASTROINTESTINAL
- ○ Indigestion _____
- ○ Reflux/heartburn_____
- ○ Nausea/vomiting_____
- ○ Bowel problems_____

HEAD & NECK
- ○ Neck pain_____
- ○ Neck lump/swelling_____
- ○ Headache_____
- ○ Facial pain _____
- ○ Jaw pain_____

SALIVARY
- ○ Need liquid to swallow dry foods_____
- ○ Mouth feels dry when eating a meal_____
- ○ Difficulties swallowing any foods_____
- ○ Sense of too little saliva_____
- ○ Sense of too much saliva_____

EYES
- ○ Vision changes_____
- ○ Dry eyes_____

EARS
- ○ Hearing loss_____
- ○ Ringing ears_____
- ○ Earaches _____
- ○ Pressure/stuffiness in ears_____

NOSE/THROAT
- ○ Congested/runny nose_____
- ○ Nose bleeds _____
- ○ Nasal obstruction _____
- ○ Sore throat _____
- ○ Hoarseness/voice changes _____
- ○ Mouth breathing/ snoring _____

PAIN
- ○ Back pain_____
- ○ Other pains _____

BEHAVIORAL
- ○ Stress_____
- ○ Sleep difficulties_____
- ○ Feel depressed _____
- ○ Feel agitated/anxious_____
- ○ Other _____

FAMILY MEDICAL HISTORY

○ **MARK HERE IF <u>NO ONE</u> IN YOUR FAMILY HAS *EVER* HAD ANY OF THE PROBLEMS LISTED BELOW**

○ **VERIFIED BY EXAMINER:**

13. **Darken the circle beside medical problems that have been present in your parents, brothers/sisters, or close relatives**.

- ○ Genetic (inherited) disease _____
- ○ Liver/kidney disease_____
- ○ Immune system disease _____
- ○ Diabetes_____
- ○ Bleeding disorders _____
- ○ Tuberculosis_____
- ○ Neurologic disease_____
- ○ Other (include cancer)_____

MEDICAL HISTORY - PAST AND PRESENT ILLNESS

14. **Darken the circle for illnesses that you CURRENTLY HAVE or HAVE HAD IN THE PAST**

○ **MARK HERE IF NONE**
○ **VERIFIED BY EXAMINER**

Cancer & Neoplastic Disease
- ○ Cancer_____
- ○ Leukemia/Lymphoma _____

Genetic (inherited) Disease
- ○ Type_____

Immune System Disorder
- ○ Rheumatoid arthritis_____
- ○ Lupus erythematosus_____
- ○ Sjogren's Syndrome_____
- ○ Other_____

Hormonal or Metabolic Disorders
- ○ Diabetes_____
- ○ Thyroid problems _____
- ○ Adrenal insufficiency_____
- ○ Other_____

Heart/Blood Disorders
- ○ High blood pressure_____
- ○ Artherosclerosis_____
- ○ Heart attack _____
- ○ Coronary artery disease_____
- ○ Heart murmur_____
- ○ Heart valve problems_____
- ○ Bleeding disorder_____
- ○ Anemia_____
- ○ Other _____

Neurological Disorders
- ○ Epilepsy/Seizures_____
- ○ Neuralgia _____
- ○ Stroke_____
- ○ Other_____

Chronic Pain
- ○ Back _____
- ○ Abdominal_____
- ○ Headache/Migraine _____
- ○ Other_____

Head and Neck Conditions
- ○ Injury to face, jaws, neck _____
- ○ Concussion_____
- ○ Radiation treatment _____
- ○ Temporomandibular joint disease _____
- ○ Salivary gland problems_____
- ○ Sinusitis _____
- ○ Glaucoma_____
- ○ Other _____

Gastrointestinal Disorders
- ○ Acid-reflux /Heartburn_____
- ○ Ulcer/Gastritis_____
- ○ Irritable bowel syndrome/Colitis _____
- ○ Other_____

Lung/Airway Disorders
- ○ Emphysema_____
- ○ Pneumonia_____
- ○ Bronchitis_____
- ○ Asthma_____
- ○ Tuberculosis_____
- ○ Sleep Apnea_____
- ○ Other_____

Skin Disorders
- ○ Skin cancer_____
- ○ Skin infections _____
- ○ Other_____

Other Major Organ Disease
- ○ Kidney disease_____
- ○ Liver disease_____
- ○ Organ transplant_____
- ○ Spleen surgery_____
- ○ Other _____

Infectious Diseases
- ○ Rheumatic fever_____
- ○ Strep Throat_____
- ○ Mononucleosis_____
- ○ Hepatitis_____
- ○ Sexually-transmitted diseases_____
- ○ HIV/AIDS _____
- ○ Other_____

Behavioral Conditions
- ○ Psychiatric illness_____
- ○ Anxiety/Panic attacks_____
- ○ Depression_____
- ○ Suicide attempt or thoughts _____
- ○ Other_____

Habits/Addiction
- ○ Drug abuse_____
- ○ Alcohol abuse_____

Other Conditions
- ○ Disabled _____
- ○ Prosthetic valve _____
- ○ Prosthetic joint _____

DOCTOR'S/ STUDENT'S USE

(Please write comments about positive responses on lines adjacent to item and use this space as needed):

15. **CONSUMPTION OF BEVERAGES AND OTHER SUBSTANCES** → ○ **MARK HERE IF NONE** ○ **VERIFIED BY EXAMINER**

a. Number of caffeinated beverages you drink in a day:
○ 0 ○ 1-2 ○ 3-5 ○ 5+

b. Number of alcoholic beverages you drink in a week:
○ 0 ○ 1-2 ○ 3-5 ○ 6-10 ○ 10+

d. Number of carbonated beverages a day:
○ 0 ○ 1-2 ○ 3-5 ○ 5+

c. Currently using any street or recreational drugs?
○ No ○ Yes (Type?)_____

e. Have you ever used tobacco? ○ No ○ Yes
If yes, what type:
○ Cigarette ○ Pipe/Cigar ○ Smokeless

f. Do you currently use tobacco? ○ No ○ Yes
If yes, average number of uses per day**:** _____
For how many years? _____

16. **DENTAL HISTORY : Darken the circle beside items that describe your past dental problems and dental care.**

○ Regular dental care
○ Occasional dental care
○ Wisdom tooth extractions
○ Orthodontics
○ Gum disease (pyorrhea, gingivitis or periodontal disease)
○ Treatment for jaw trauma/fracture (Type?)_____
○ Had an adverse reaction to dental treatment (Please describe)_____
○ Dental fears or anxiety_____

17. Rate your ORAL HEALTH in general. ○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor

18. How good a job do you feel you are doing in taking care of your oral health?
○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor

19. Date of last regular dental visit: ____ _____ Name and address of dentist: _____
Month Year _____
_____

FAMILY DENTAL HISTORY

20. Darken the circle beside oral problems that have been present in your parents, brothers/sisters, or close relatives.
○ Caries ○ Gum disease (pyorrhea, gingivitis or periodontal disease) ○ Dry Mouth ○ TMJ disorder

DOCTOR'S/ STUDENT'S USE

Additional Notes or Comments:

Patient's Signature_____**Date**_____

Reviewed by (Student)_____
Date_____

Reviewed by (Faculty) _____
Date_____