Adult Oral and Systemic Health History

While dentistry is our primary purpose, we believe you want a healthy mouth and a healthy body. Let us partner with you for both.

Name _____ Date of Birth _____ Today's Date _____

Signature _____ Office Witness _____

Primary care physician _____ Last physical exam date: _____

Other medical providers _____

Caries (tooth decay):

Do you consider yourself cavity prone?	Y	N
Do you consume sugary foods on a regular basis?	Y	N
How much plain water do you drink daily? _____		
Do you consume any citrus flavored beverages?	Y	N
Does your mouth feel dry?	Y	N
Do you have heartburn or reflux?	Y	N
What dental products do you use? _____		

Oral Cancer:

Do you smoke, vape, or chew tobacco?	Y	N
Do you have any persistent sore spots in your mouth or lumps/bumps in your head or neck?	Y	N
Do you feel as if you have a lump in your throat?	Y	N
Do you use cannabis in any form?	Y	N

Cancer:

Do you have a cancer diagnosis or history?	Y	N
Are you currently undergoing cancer treatment?	Y	N
Have you ever received chemotherapy or radiation treatment?	Y	N
Do you have any known risks for a specific cancer?	Y	N

Pre-Diabetes and Diabetes:

Have you ever been diagnosed with prediabetes or diabetes?	Y	N
Do you take medications for diabetes?	Y	N
Do you have any biologic family members with diabetes?	Y	N
Do you know your A1C?	Y	N
If yes, what is it? _____		

Periodontal Disease:

Have you been told you have gingivitis or gum disease in the past?	Y	N
Do your gums ever bleed when you brush or floss?	Y	N
Do you have gum recession or exposed root surfaces?	Y	N
Do you have any loose teeth, drifting teeth, or areas that collect food when you eat?	Y	N

Cardiovascular Disease:

Are you currently being treated for cardiovascular disease?	Y	N
Have you had any heart valves replaced?	Y	N
Do you have a history of heart attack, stroke, bypass surgery, stents, or pacemaker?	Y	N
Do you experience shortness of breath or chest pain?	Y	N
Do you have a family history of heart disease?	Y	N
Do you take anti-cholesterol medication?	Y	N
Have you ever been diagnosed or treated for high BP?	Y	N
If so, is it currently controlled?	Y	N
Do you currently take blood pressure medication?	Y	N
Do you monitor your own blood pressure?	Y	N
If so, what is it usually? _____		

Exercise:

Do you exercise regularly?	Y	N
If so, how many times per week? _____		
What type? _____		

Sleep:

Do you ever snore?	Y	N
Do you experience interruptions in breathing during sleep?	Y	N
Do you have difficulty sleeping?	Y	N
Do you feel tired or fatigued during the day?	Y	N
Have you had a sleep study performed?	Y	N
Do you have a CPAP or oral sleep appliance?	Y	N

Medical Care:

Do you seek annual preventive medical services? Y N
Have you ever been diagnosed with dementia, depression, anxiety disorder or any other brain function ailment? ..... Y N
Do you follow a special diet? ..... Y N
Have you gained or lost weight unexpectedly in the last year? ..... Y N
Are you pregnant? ..... Y N
If yes, what month? _____
Are you on birth control (pills, patch, implant)? ... Y N
Do you have menopausal symptoms? ..... Y N
Are you currently being treated for any medical conditions? ..... Y N
If so, please list: _____
_____
Are you aware of being treated for any vital organ disease such as diseases of the thyroid, lungs, liver, kidneys, uterus, pancreas, or brain? ..... Y N
If so, please list: _____

Non-elective surgeries: _____
_____

Elective Surgeries: _____
_____

Please circle any of these conditions you have or have had:

Heart Murmur Anemia Blood Transfusion

Bleed Easily Bruise Easily Hepatitis: A B C

Stroke Epilepsy or Seizures Ulcers

Glaucoma Fainting Spells HIV/AIDS

STD/STI Cold Sores/Fever Blisters

Yellow Jaundice Cortisone Treatment Rheumatic Fever

Scarlet Fever Steroid Treatment

Allergies, Food Sensitivities, and Other Chronic Inflammatory Conditions:

Are you aware of any chronic inflammatory conditions such as irritable bowel syndrome, fibromyalgia, arthritis, chronic fatigue syndrome, or insulin resistance? ..... Y N
If so, please list: _____
_____
Are you aware of any allergies? ..... Y N
If so, please list: _____
_____
Have you identified any food sensitivities such as dairy, wheat or soy? ..... Y N
Do you suffer from GI disturbance such as discomfort, bloating, constipation, or diarrhea? ..... Y N
Do you ever have heartburn, regurgitation, or acid reflux? Y N
Do you have red, patchy or itchy skin, or itchy ears? ..... Y N

Dependency/Addiction:

Are you currently in recovery or being treated for addiction? ..... Y N
Do you smoke or chew tobacco? ..... Y N
Do you depend on any prescription or non-prescription drugs to sleep, wake, or relieve pain? ..... Y N
Do you feel you are addicted to any sugar? ..... Y N

Breathing:

Have you been diagnosed with (please circle all that apply):

Asthma Emphysema COPD

Tuberculosis Chronic Cough Sinus Trouble

Bone and Joint Health:

Have you been diagnosed with Osteopenia or Osteoporosis? ..... Y N
Have you had an abnormal bone density test?..... Y N
Have you been treated with oral or injectable medications for Osteoporosis? ..... Y N
Have you had joint surgery or joint replacement? ..... Y N
If so, which joint? _____
Have you taken antibiotics for dental appointments as a result of joint replacement? ..... Y N

FOR OFFICE USE ONLY:

_____
_____
_____