

NAME: _____ DATE: _____ CHART: _____

UNIVERSITY OF WASHINGTON SCHOOL OF DENTISTRY - MEDICAL AND DENTAL HISTORY

GENERAL INFORMATION

1. a. Date of Birth: _____ b. Gender: Male Female c. Weight: _____ lbs.
 Month Day Year 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 _____ Going through menopause? Post-menopausal?
 (Name of Prescription)

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 NO ONE 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 _____