Southside Community Health Services
Dental Clinic

Last Name	Middle Name	Sex/ Gender pronouns	Date of Birth / /
First Name			

When did you last visit your doctor for a regular checkup? ____________________

Physician/Clinic________________________ Address________________________

Check ☑ "Yes" or "No" for any of the following

Yes or No

❑ or ❑ **Heart Disease/Problems**

If yes:
- ❑ Heart Replacement ❑ Valve Damage
- ❑ Pacemaker ❑ Valve Replacement
- ❑ Rheumatic Fever w/ Heart Damage
- ❑ Previous history of Endocarditis
- ❑ Congenitial unrepaired heart valve

❑ or ❑ **Stroke** When?____________

❑ or ❑ **High Blood Pressure**

❑ or ❑ **Epilepsy or Seizures** Last seizure? ________

❑ or ❑ **Diabetes** ❑Insulin Glucose________ ❑Oral meds A1C________

❑ or ❑ **Asthma** Last attack? __________

❑ or ❑ **Kidney/Bladder Trouble** Dialysis**?**_____

❑ or ❑ **Thyroid Disease** ___________

❑ or ❑ **Tuberculosis / Positive TB test**

❑ Medications taken? How Long?_______

❑ or ❑ **Liver Disease** ___________

❑ or ❑ **Arthritis**

Rheumatoid arthritis effecting the heart?______

❑ or ❑ **Have you ever taken Bisphosphonates**?

When? ________

❑ or ❑ **Artificial Joint**

What joint?_________________

Date Placed _____ / _____ / _____

❑ or ❑ **Cancer or Tumor** When? ______________

❑ or ❑ **Hepatitis (A,B,C) or Jaundice** Which? ___

(office use only) ***Blood Pressure***:__________________

Yes or No

❑ or ❑ **HIV or AIDS**

❑ or ❑ **Sexually Transmitted Infections** (syphilis, gonorrhea, herpes etc.) Which? _________

❑ or ❑ **Persistent Cough, Cough up Blood**

❑ or ❑ **Anxiety or Depression** ________________

Receiving treatment/controlled? _________

❑ or ❑ **Psychiatric Treatment** Diagnosis? ______

❑ or ❑ **Alcohol or Drug Abuse/Addiction**

Which? ________

❑ or ❑ **Anemia**

❑ or ❑ **Acid Reflux or Eating Disorder** _________

❑ or ❑ **COPD/Emphysema/Lung disease** ________

❑ or ❑ **Glaucoma or Eye Disease**

❑ or ❑ **Blood Disorders** ____________ INR? ____

❑ or ❑ **Ulcers or Stomach Disease** ___________

❑ or ❑ **Autoimmune Disorder/Lupus?** __________

❑ or ❑ (Ages 9-26 only): **Received the HPV vaccination?**_____________

❑ or ❑ **Chronic Pain**? _____________

❑ or ❑ **Do you smoke or use tobacco?** How often?__________

❑ or ❑ **Any disease or condition not listed**?_______________

❑ or ❑ On a **blood thinner/experienced excessive bleeding**?__________

❑ or ❑ Have you ever been **hospitalized**? What for?:________________

❑ or ❑ **Radiation Treatment**? What was radiated?_________

Are you allergic to any medications, or latex?

Yes or NO __________

Women only:

❑ or ❑ **Are you pregnant**? Due Date:_____ / _____ / _____

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Medications (please list)

For Children Only

Yes or No

❑ or ❑ Do your children ONLY drink bottled water?

❑ or ❑ Do you put your child to bed with a bottle? What is in it? ___________________________

Do you have any of the following?

- ❑ Toothaches
- ❑ Bad Breath
- ❑ Bleeding Gums
- ❑ Cold Sores
- ❑ Canker Sores
- ❑ Clenching/Grinding teeth
- ❑ Clicking or popping jaw
- ❑ Jaw locked open or closed
- ❑ Periodontal or gum treatment
- ❑ Sensitive teeth

Dental History

Did you have 18 small x-rays or a panorex? **Yes or NO** If Yes When? ____________________

When was your last cleaning? ____

When was your last x-rays or dental treatment? ______________________________

With what dentist? ____

Are you having problems now? ____

A parent or guardian must sign for under 18 years old

DDS/DH Signature

Patient/Guardian Signature______________________ Date __/__/____ __________

Updated______________________ Date __/__/____ __________