Universal Health History

General Information

First Name: ☐ Middle Initial: ☐ Last Name: ☐

Date of Birth: ☐ Gender: ☐ Male ☐ Female

Email Address: ☐

Home Phone: ☐ Mobile Phone: ☐ Work Phone: ☐

Address: ☐ City: ☐ State: ☐

ZIP: ☐ Method of Contact: ☐ Home Phone ☐ Work Phone ☐ Mobile Phone ☐ Text Message ☐ Email

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Referred by: ☐

Emergency Contact:

First Name ☐ Last Name ☐

Phone ☐ Relation ☐

Universal Health History

Medical History

Reason for today's office visit?

Height: **Weight (lbs):**

Please Rate Your Health: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Have there been any changes in your general health in the past year?

Are you under the care of a physician? ☐ Yes ☐ No

Do you have an artificial joint? ☐ Yes ☐ No

Have you had a heart valve replacement? ☐ Yes ☐ No

Has a physician or previous dentist recommended that you take antibiotics prior to dental treatmeant? ☐ Yes ☐ No

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Have your ever been treated with bisphophonates such as Zometa, Aredia, Actonel, Fosamax or Boniva? ☐ Yes ☐ No

Are you currently on any steroid medications? ☐ Yes ☐ No

Are you taking blood thinners such as Coumadin, Plavix, Aspirin, Vitamin E, Ginko Biloba, Aggrenox, Pradaxa or Fish Oil? ☐ Yes ☐ No

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Physician Information

Physician's Full Name:

Address:

City: **State:** **ZIP:**

Physician's Phone:

Date of Last Visit:

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Current/Previous Conditions

Medical Alerts

Please indicate if you have experienced allergic reactions to any of the following:

- ☐ Aspirin
- ☐ Penicillin, kflex
- ☐ Codeine, vicodin, percodan
- ☐ Erythromycin
- ☐ Barbiturates, sedatives or sleeping pills
- ☐ Narcotics, demerol, morphine
- ☐ Tetracycline
- ☐ Tranquilizers, valium, versed, halcion
- ☐ Latex
- ☐ Iodine
- ☐ Dental anesthetics, general anesthetics
- ☐ Metal / Plastic (including jewelry)

Any other allergies or reactions not listed?

Medical Conditions

Please indicate if you have experienced any of the following:

- ☐ Rheumatic fever
- ☐ Emphysema
- ☐ Damaged heart valves / mtral valve prolapse
- ☐ Heart murmur
- ☐ HighBlood Pressure
- ☐ Smoke Cigarettes
- ☐ Low Blood Pressure
- ☐ Liver Disease
- ☐ Do you use chewing tobacco?
- ☐ Chest pain / angina
- ☐ Hepatitis, jaundice
- ☐ Heart attack(s)
- ☐ High cholesterol
- ☐ Irregular heart beat
- ☐ Kidney disease
- ☐ Cardiac pacemaker
- ☐ Are you on dialysis?
- ☐ Heart Surgery
- ☐ Diabetes
- ☐ Blood transfusion
- ☐ Low blood sugar

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- ☐ Blood disorder / anemia
- ☐ Fainting spells
- ☐ Bruise easily
- ☐ Convulsions / epilepsy
- ☐ Bleeding tendency
- ☐ Sexually transmitted diseases
- ☐ Thyroid trouble
- ☐ Asthma
- ☐ Pneumonia, bronchitis, chronic cough
- ☐ Gallbladder trouble
- ☐ Hay fever / sinus problems
- ☐ Stomach ulcers / acid reflux
- ☐ Hives / skin rash
- ☐ Swollen ankles / arthritis
- ☐ Difficulty breathing / other lung trouble
- ☐ Joint disease
- ☐ Snoring / sleep apnea
- ☐ Osteoporosis / osteopenia
- ☐ Tuberculosis
- ☐ Stroke
- ☐ Hearing loss
- ☐ Tumor or growth
- ☐ Cancer
- ☐ Radiation therapy / chemotherapy
- ☐ Delay with healing
- ☐ Artificial joints
- ☐ Autoimmune / Immune system disease
- ☐ Contact Lenses
- ☐ Eye disease /glaucoma
- ☐ Chronic fatigue / night sweats
- ☐ History of alcohol abuse
- ☐ History of drug abuse
- ☐ Psychiatric treatment / anxiety / depression

Prescription / Non Prescription Medications

Name	Type of Condition	Dose / Frequency of Use

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Dental History

General Dental Information

What is your primary reason for seeking dental care?

Please indicate if you have experienced any of the following:

Decay / Bacterial Disease

- ☐ Frequent Decay
- ☐ Lost / Broken fillings
- ☐ Stained Teeth
- ☐ Bad Tase Odor
- ☐ Tooth Loss
- ☐ Do you have growths or sores in your mouth?

Periodontal Disease / Bone Loss

- ☐ Bleeding Gums
- ☐ Gum recession
- ☐ Missing Teeth
- ☐ Worn Teeth
- ☐ Change In Bite
- ☐ Tender or Sore Gums
- ☐ Acscess / Infections
- ☐ Occlosal Disease / Wear
- ☐ Jaw popping or clicking
- ☐ Loose Teeth
- ☐ Sensitive teeth...hot, cold, sweet, biting
- ☐ Food Catching between your teeth
- ☐ Do you clench or grind your teeth
- ☐ Difficulty opening your mouth
- ☐ Do you wake with a headache or jaw pain

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Previous Dentist Information

Dentist's Full Name:

Street Address:

City: **State:** **ZIP:**

Phone:

Date of Last Visit: **Date of Last X-Rays:**

Dental Conditions

Please indicate if you have experienced any of the following:

Orthodontic Treatment? ☐ Yes ☐ No If Yes, how long ago?

Periodontal Treatment? ☐ Yes ☐ No If Yes, how long ago?

Have you had previous problems with dental care? If so, explain:

Are you nervous about receiving dental treament? ☐ Yes ☐ No

How can we help you feel more comfortable during dental treatment?

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Do you currently have existing crowns and bridges? ☐ Yes ☐ No

Are you currently wearing dentures or removable partial denture? ☐ Yes ☐ No

Do you currently have dental implants? ☐ Yes ☐ No

Do you have any questions about dental implants?

On a scale of #1-10 how would you rate your oral health in general? (1 = Poor; 10 = Excellent)

Rate these in terms of most importance to you. (1 = Most Important; 4 = Least important)

Cost:

Health:

Comfort:

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Appearance: [ ]

Are you happy with your smile? ☐ Yes ☐ No

Have you budgeted beyond dental insurance for you necessary dental care? ☐ Yes ☐ No

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Authorization

I hereby certify that I have read and understand the previous information and that is accurate and true to the best of my knowledge. I also understand it is very important to report any changes or updates in my medical status. I give permission to obtain from my physician any additional information regarding my medical history needed to provide me with the best treatment possible.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs or other diagnostic aids deemed appropriate. I authorize the sharing of this information with my Centergistix team to minimize duplication and cost. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in completion of this form.

Signature:

Date:

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