

FLORIDA ATLANTIC UNIVERSITY – STUDENT HEALTH SERVICES DENTAL CLINIC

PLEASE COMPLETE ALL INFORMATION REQUESTED

Name: _____ Z-Number: _____ Date of Birth: _____ Phone: _____

Sex assigned at birth: ☐ female ☐ male What pronouns do you use: ☐ she/her/hers ☐ he/him/his ☐ they/them/their ☐ anything else: _____Gender identity: ☐ woman ☐ man ☐ gender queer ☐ trans woman ☐ trans man ☐ prefer not to say ☐ self-identify: _____

Patient's Dentist: _____ Address: _____ Phone: _____

Patient's Physician: _____ Address: _____ Phone: _____

Last Dental Visit: _____ What was done at the time: _____ Last Cleaning: _____ Last X-Rays: _____

Reason for visit today: _____

DENTAL HISTORY

	Yes	No		Yes	No
1. Do you have any pain in your mouth today? If yes, where? (please circle) gum / tooth / other	<input type="checkbox"/>	<input type="checkbox"/>	14. Do you have any of the following? (check all that apply)		
2. Are you currently experiencing any of the following? (please circle) headache / neck pain / ear pain	<input type="checkbox"/>	<input type="checkbox"/>	Artificial heart valve	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have any bleeding in your mouth today?	<input type="checkbox"/>	<input type="checkbox"/>	History of heart transplant	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have any swelling in your mouth today? If yes, where? (please circle) gum / other	<input type="checkbox"/>	<input type="checkbox"/>	Congenital heart problems	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any of the following? (check all that apply)			High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Dry mouth or difficulty chewing	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Temporal mandibular joint (TMJ) pain or discomfort	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
Lesions/ulcers/sores around your mouth	<input type="checkbox"/>	<input type="checkbox"/>	History of endocarditis	<input type="checkbox"/>	<input type="checkbox"/>
Discolored or stained teeth	<input type="checkbox"/>	<input type="checkbox"/>	15. Do you have a history of the following? (check all that apply)		
Bad breath	<input type="checkbox"/>	<input type="checkbox"/>	Eating disorders	<input type="checkbox"/>	<input type="checkbox"/>
Teeth sensitivity to cold/hot/sweet/pressure	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal disease	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you had any of the following? (check all the apply)			Gastric reflux (also known as GERD or heartburn)	<input type="checkbox"/>	<input type="checkbox"/>
Periodontal (gum) disease	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Orthodontic (braces) treatment	<input type="checkbox"/>	<input type="checkbox"/>	16. Are you allergic to any of the following? (check all that apply)		
Oral surgery	<input type="checkbox"/>	<input type="checkbox"/>	Medication	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you been diagnosed with any of the following? (please circle) asthma / bronchitis / emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Local anesthesia	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you been diagnosed with any of the following conditions that affect your immune system? (please circle) AIDS / HIV/ other	<input type="checkbox"/>	<input type="checkbox"/>	Latex	<input type="checkbox"/>	<input type="checkbox"/>
			Milk protein	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you been diagnosed with TB (tuberculosis)?	<input type="checkbox"/>	<input type="checkbox"/>	Clove oil	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you been diagnosed with diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		
If yes, are you under a physician's care?	<input type="checkbox"/>	<input type="checkbox"/>	17. Are you currently taking any medications, including contraceptives, supplements, and over the counter medications? If so, please list.	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you have any bleeding disorders? (please circle) hemophilia / anemia / need for blood transfusions / take a blood thinner	<input type="checkbox"/>	<input type="checkbox"/>	_____		
12. Have you ever had seizure or fainting spells?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
13. Have you had total joint replacement surgery? If yes, have you had any complications? (circle one) yes / no	<input type="checkbox"/>	<input type="checkbox"/>	_____		
			18. Do you have any condition not listed above that you think we should know about?	<input type="checkbox"/>	<input type="checkbox"/>

			19. FEMALES ONLY. Are you pregnant or currently nursing?	<input type="checkbox"/>	<input type="checkbox"/>

DENTAL HABITS

1. Do you grind or clench your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	5. How many times a day do you brush your teeth? _____
2. Do you chew on ice or other foreign objects?	<input type="checkbox"/>	<input type="checkbox"/>	6. Any other habits we should know about? _____
3. Do you use tobacco, marijuana, or vaping products?	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Do you floss daily?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Patient Signature _____

Date _____

Providers Signature _____

Date _____