

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

			19. FEMALES ONLY. Are you pregnant or currently nursing?	☐	☐

DENTAL HABITS

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

Patient Signature _____

Date _____

Providers Signature _____

Date _____