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
1.	**Do you have any pain in your mouth today? If yes, where? (please circle)** gum / tooth / other	☐	☐
2.	**Are you currently experiencing any of the following? (please circle)** headache / neck pain / ear pain	☐	☐
3.	**Do you have any bleeding in your mouth today?**	☐	☐
4.	**Do you have any swelling in your mouth today? If yes, where? (please circle)** gum / other	☐	☐
5.	**Do you have any of the following? (check all that apply)**		
	Dry mouth or difficulty chewing	☐	☐
	Temporal mandibular joint (TMJ) pain or discomfort	☐	☐
	Lesions/ulcers/sores around your mouth	☐	☐
	Discolored or stained teeth	☐	☐
	Bad breath	☐	☐
	Teeth sensitivity to cold/hot/sweet/pressure	☐	☐
6.	**Have you had any of the following? (check all the apply)**		
	Periodontal (gum) disease	☐	☐
	Orthodontic (braces) treatment	☐	☐
	Oral surgery	☐	☐
7.	**Have you been diagnosed with any of the following? (please circle)** asthma / bronchitis / emphysema	☐	☐
8.	**Have you been diagnosed with any of the following conditions that affect your immune system? (please circle)** AIDS / HIV/ other	☐	☐
	_____		
9.	**Have you been diagnosed with TB (tuberculosis)?**	☐	☐
10.	**Have you been diagnosed with diabetes?**	☐	☐
	If yes, are you under a physician's care?	☐	☐
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		

		Yes	No
14.	**Do you have any of the following? (check all that apply)**		
	Artificial heart valve	☐	☐
	History of heart transplant	☐	☐
	Congenital heart problems	☐	☐
	High blood pressure	☐	☐
	Shortness of breath	☐	☐
	Chest pain	☐	☐
	History of endocarditis	☐	☐
15.	**Do you have a history of the following? (check all that apply)**		
	Eating disorders	☐	☐
	Gastrointestinal disease	☐	☐
	Gastric reflux (also known as GERD or heartburn)	☐	☐
	Ulcers	☐	☐
16.	**Are you allergic to any of the following? (check all that apply)**		
	Medication	☐	☐
	Local anesthesia	☐	☐
	Latex	☐	☐
	Milk protein	☐	☐
	Clove oil	☐	☐
	Other:_____		
17.	**Are you currently taking any medications, including contraceptives, supplements, and over the counter medications? If so, please list.**	☐	☐
	_____		
	_____		
	_____		
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?	☐	☐
2.	Do you chew on ice or other foreign objects?	☐	☐
3.	Do you use tobacco, marijuana, or vaping products?	☐	☐
4.	Do you floss daily?	☐	☐

5. How many times a day do you brush your teeth? _____
6. Any other habits we should know about?

_____

_____

Patient Signature Date

Providers Signature Date