UNIVERSITY OF FLORIDA COLLEGE OF DENTISTRY
MEDICAL QUESTIONNAIRE

Hygiene License Number ______________
Date ______________________

Name ____ **Date of Birth** _______________

Occupation ____

Please answer the following 3 questions by filling in the blanks. If you need help, ask the receptionist or your dental student.

1. Chief complaint: **What is or are your reasons for being here?** **History of chief complaint:**	**1.** ______________________________________ ______________________________________ ______________________________________ ______________________________________ ______________________________________
2. Is there anything or anyone preventing you From seeking appropriate medical/dental care?	**2.** ______________________________________ ______________________________________
3. Last dental visit and reason for visit:	**3.** ______________________________________ ______________________________________ ______________________________________

4. Past dental history (check all previous dental services received):

- ☐ **Dental exam with x-rays**
- ☐ **Tooth extraction or oral surgery**
- ☐ **Restorations (fillings)**
- ☐ **Partial dentures (removable)**
- ☐ **Crown and bridgework (fixed)**
- ☐ **Special diagnostic exam – Explain** ______________________________________
- ☐ **Complete dentures (plates)**
- ☐ **Periodontal treatment (gum treatment)**
- ☐ **Endodontic treatment (root canal treatment)**
- ☐ **Orthodontic treatment (braces)**

5. Previous dental experiences

- ☐ **Unpleasant experience with dentist(s) in past (describe)** ______________________________
- ☐ **Pleased with previous dental experience**

6. Self analysis of oral health (check any problems that you have)

- ☐ **Bad teeth (cavities)**
- ☐ **Crooked teeth**
- ☐ **"Dry Mouth" (not enough saliva)**
- ☐ **Bad bite: bite feels off**
- ☐ **Frequent sores in mouth or on lips**
- ☐ **Teeth painful to hot, cold, sweets (underline which)**
- ☐ **Other problems (describe)** ______________________________________
- ☐ **Bleeding gums**
- ☐ **Swelling in mouth or jaws on occasion (underline which)**
- ☐ **Loose or drifting teeth**
- ☐ **Food catching between teeth**
- ☐ **Bad taste in mouth**
- ☐ **Severe toothaches**

7. Attitudes about dentistry

Y	**N**	
☐	☐	**Most people will eventually lose their teeth.**
☐	☐	**Good dental care can prevent tooth loss.**
☐	☐	**Do you only see the dentist for emergency care?**
☐	☐	**Do you brush every day?**
☐	☐	**Do you floss every day?**

8. Oral Habits

☐	☐	**Do you or have you ever smoked cigarettes?**	**Frequency:** __________ **packs per day** ________ **years**
☐	☐	**Do you chew tobacco or use snuff?**	**Frequency:** __________ **times per day** ________ **years**
☐	☐	**Do you drink alcohol?**	**Frequency:** __________ **times per day**
☐	☐	**Do you chew gum?**	**Frequency:** __________ **sticks per day**
☐	☐	**Do you drink sugary drinks frequently?**	**Frequency:** __________ **number of 12 oz cans per day**

HEALTH HISTORY
Review of Systems

Please do not write in spaces below

CARDIOVASCULAR

	Yes	No	
1.	☐	☐	Have you ever been told you have heart trouble?
2.	☐	☐	Have you ever been told you have ☐ high or ☐ low blood pressure
3.	☐	☐	Do you get out of breath easily?
4.	☐	☐	Have you had rheumatic fever?
5.	☐	☐	Do you have a heart murmur as a consequence of rheumatic fever?
6.	☐	☐	Do you have a prolapsed mitral valve?
7.	☐	☐	Have you ever been told that you have a heart murmur of any cause?
8.	☐	☐	Have you ever been told to take antibiotics before dental treatment?
9.	☐	☐	Have you had a heart attack?
10.	☐	☐	Have you had a stroke?
11.	☐	☐	Do your ankles become easily swollen?
12.	☐	☐	Do you suffer from angina pectoris (chest and left arm pain)?
13.	☐	☐	Have you ever taken the weight reduction drug Fen-phen?

SENSES

1.	☐	☐	Have you had earaches or other ear problems?
2.	☐	☐	Have you had eye problems such as glaucoma or other problems?
3.	☐	☐	Have you noticed any changes in your sense of taste or smell?
4.	☐	☐	Do you have bad breath (halitosis)?
5.	☐	☐	Do you have headaches?
6.	☐	☐	Do you feel tired or have significant body discomfort?
7.			How well do you sleep? ☐Excellent ☐Good ☐Fair ☐Poor
8.	☐	☐	Do you wake up feeling tired?
9.			Do you snooze during the day? ☐None ☐A Little ☐Some ☐A Lot

RESPIRATORY

1.	☐	☐	Do you have the flu or a cold more than twice a year?
2.	☐	☐	Do you have asthma, hayfever, sinusitis, or frequent sore throats?
3.	☐	☐	Have you had pneumonia or a lung infection?
4.	☐	☐	Do you have, or have you been exposed to, tuberculosis?
5.	☐	☐	Do you have a chronic cough or cough up blood?
6.	☐	☐	Do you have bronchitis or emphysema?

NEUROLOGIC

1.	☐	☐	Have you ever been under psychiatric care or had counseling?
2.	☐	☐	Do you have numbness or tingling feelings anywhere?
3.	☐	☐	Have you ever had a nervous breakdown?
4.	☐	☐	Are you anxious or depressed frequently?
5.	☐	☐	Do you have epilepsy, seizures, or other neurologic disorders?

ENDOCRINE

1.	☐	☐	Do you have diabetes?
2.	☐	☐	Does any member of your family have diabetes?
3.	☐	☐	Are you thirsty frequently or urinate frequently?
4.	☐	☐	Do you have thyroid problems or take thyroid tablets?
5.	☐	☐	Do you have any other gland problems?

G-I

1.	☐	☐	Have you had jaundice, liver trouble or hepatitis?
2.	☐	☐	Do you have stomach problems or ulcers?
3.	☐	☐	Do you have frequent or prolonged diarrhea or constipation?
4.	☐	☐	Do you have frequent episodes of acid reflux or vomiting?
5.	☐	☐	Has your weight changed more than 20 pounds in the past year?

G-U

1.	☐	☐	Have you ever been told that you have kidney or bladder trouble?
2.	☐	☐	Have you had any sexually transmitted disease (syphilis, gonorrhea, genital herpes, HIV infection, AIDS)?
3.	☐	☐	Have you had any reproductive tract problems?

HEMATOLOGY

1.	☐	☐	Have you had anemia?
2.	☐	☐	Do you have leukemia?
3.	☐	☐	Do you bruise or bleed easily?

IMMUNOLOGY	**Yes No** **1. ☐ ☐ Are you sensitive or allergic to any medications? (penicillin,** **2. sulfa drugs, aspirin, etc)** **3. ☐ ☐ Are you allergic to any foods, metals, pollens or latex (rubber)?** **4. ☐ ☐ Have you been treated for a skin disease?** **5. ☐ ☐ Do you have a defective immune system?** **6. ☐ ☐ Do you take medications that suppress your immune system?**	
MUSCSKEL	**1. ☐ ☐ Are your joints often painfully swollen or do you have arthritis?** **2. ☐ ☐ Do you have back problems?** **3. ☐ ☐ Have you had more than one fracture or dislocation?** **4. ☐ ☐ Do you have osteoporosis?** **5. ☐ ☐ Have you ever taken drugs for osteoporosis/osteopenia or as part of therapy for cancer or cancer prevention?** **If you answered "yes" to question #5. above, please answer questions #6 - #11.** **If you answered "no" to #5, skip to the next section.** **6. Name and dosage of medication for bones ________________________________** **7. When did you start taking it? ____** **8. Are you still taking it? ____** **9. When did you stop taking it? ____** **10. Did you take it by "mouth" or by "injection or shot" (circle)**	
SURGERY-ANESTHESIA	**1. ☐ ☐ Have you had an operation?** **2. ☐ ☐ Have you had a series of shots or injections?** **3. ☐ ☐ Have you ever had anesthesia? ☐ Local ☐ General** **4. ☐ ☐ Have you ever been told not to take novocaine or any other medication?** **5. ☐ ☐ Have you ever been told you had cancer or a tumor?** **6. ☐ ☐ Have you ever had chemotherapy?** **7. ☐ ☐ Have you ever had radiation therapy?** **8. ☐ ☐ Have you ever had an organ or bone marrow transplant?** **9. ☐ ☐ Are you using any recreational drugs or substances?** **10. ☐ ☐ Are you an active or recovering substance abuse?**	
IMPLANTS	**1. ☐ ☐ Do you have a prosthetic (artificial) heart valve?** **2. ☐ ☐ Do you have a pacemaker or defibrillator?** **3. ☐ ☐ Have you had vascular or cardiac repair with synthetic materials?** **4. ☐ ☐ Do you have a vascular shunt (hemodialysis or drug therapy)?** **5. ☐ ☐ Do you have any prosthetic joints (hip, knee, ankle, shoulder)?** **6. ☐ ☐ Do you have any other implant?**	
FACIAL PAIN	**1. ☐ ☐ Do you have a history of head or neck injury?** **2. ☐ ☐ Have you ever had severe pains of the face or head?** **3. ☐ ☐ Do you suffer from headache, eye pain or migraine?** **4. ☐ ☐ Do you have ear pain or pain in front of our ears?** **5. ☐ ☐ Does anything hurt when you chew?** **6. ☐ ☐ Does your jaw make noise that bothers you or others?** **7. ☐ ☐ Does the pain or discomfort interfere with your work activities?**	
WOMEN	**For Women Only:** **1. ☐ ☐ Are you taking birth control pills or have Norplant?** **2. ☐ ☐ Are you pregnant? Expected delivery date: _________** **3. ☐ ☐ Are you breast feeding?**	

I verify that, to the best of my knowledge, the above health history is correct: ________________________________

Patient Signature

Overall health ____

When was the patient's last physical exam by a Physician? ______________________________

Physician's Name(s): ____

Address(es) ____

Phone(s) (   ) ____

HOSPITALIZATIONS OR OUTPATIENT PROCEDURES	Year	City	Procedure	Complications

INITIAL SUMMARY					
	BLOOR PRESSURE:		PULSE:		
	Student/Number	Medical Consult Requested Yes No	Faculty/Number	Consult Received (Faculty Name/#)	Date
		Reason:			