BLACK HAWK DENTAL CLINIC
Health History

Today's Date: _____ Dentrix Chart No *(completed by dental staff)* : _____

PATIENT INFORMATION

Name: _____ Date of Birth: _____
Last First MI
Phone Number: _____
Preferred Name: _____ Pronouns: They/Them, She/Her, He/Him

Address: _____ _____
Street City State Zip

PREFERENCES

During treatment I would prefer if my provider were…
☐Bubbly/Talkative ☐No Preference ☐Gets straight to business; I'd prefer not to chat too much.
When reviewing treatment options, I would like my provider to…
☐ Explain the details of multiple options in-depth. ☐ Direct me; explain their strongest recommendation first.

Describe your dental goals/anxieties here. Include anything that might help us care for you (even your personal interests!).
_____
_____
_____

CURRENT HABITS

How often do you **brush** your teeth? ☐Twice Daily ☐Evenings only ☐Mornings Only ☐Most Days ☐Rarely
What kind of **toothbrush** do you use? ☐Electric ☐Manual (regular)
What brand of **toothpaste** do you use? _____
Is there **fluoride** in your toothpaste? ☐Yes ☐Not Sure ☐No
How often do you **floss**? ☐Daily ☐Sometimes ☐Rarely
What **type** of floss do you use? ☐String ☐Proxabrush ☐Picks
What type of **mouthwash** do you use? ☐Biotene ☐Listerine/Act ☐Therabreath ☐Other ☐None

What do you **drink** regularly other than water? *(mark all that apply)*
☐Unsweetened tea ☐Milk ☐Sweet tea ☐Fruit juice ☐Sports drinks ☐Soda ☐Energy drinks
☐Water only ☐Other/Describe: _____
How would you describe your **drinking** frequency? ☐ Drink all at once/at mealtimes ☐ Sip on drinks all day
How would you describe your **eating** frequency? ☐ I eat mainly at mealtimes ☐ I snack often

Oral Habits: ☐Sucking ☐Biting fingernails ☐Clenching/Grinding ☐Chewing non-food items
☐Cheek biting ☐Tongue thrusting ☐Mouth breathing ☐Toothpick/Stimulator use
Other: _____

DENTAL HISTORY	No	Yes		No	Yes
Previous facial/mouth trauma	☐	☐	Dry mouth	☐	☐
TMJ/tooth grinding concerns	☐	☐	Bad breath concerns	☐	☐
Sores on/around your mouth	☐	☐	Generalized tooth sensitivity	☐	☐
On gums, tongue, throat, cheeks (changes)	☐	☐	Tooth pain/concerns	☐	☐
On lips, roof of mouth (same spot each time)	☐	☐	☐One tooth ☐Multiple teeth ☐Jaw/Face		

Other: _____

MEDICAL HISTORY *If yes, describe and date*

	No	Yes		No	Yes
Stroke	☐	☐	Seizures/Epilepsy/Fainting	☐	☐
Heart Attack	☐	☐	Frequent vomiting	☐	☐
Heart Conditions	☐	☐	GERD/ulcers	☐	☐
Glaucoma	☐	☐	Liver disease/Cirrhosis	☐	☐
Hemophilia/Anemia/bleeding disorder	☐	☐	Kidney disease/Dialysis	☐	☐
Autoimmune disorders	☐	☐	Chronic pain/pain management	☐	☐
Cancer	☐	☐	Lung conditions	☐	☐
Diabetes	☐	☐	Asthma	☐	☐
HIV/AIDS	☐	☐	Sinus trouble	☐	☐
Hepatitis C	☐	☐	Autism Spectrum Disorder	☐	☐
Intellectual/Developmental Disabilities				☐	☐
Mental Health Disorders (Depression, Anxiety, Bipolar Disorder, Schizophrenia, etc.)				☐	☐

Other Conditions/Syndromes: _____

Medications *(check all that apply)*

☐ I receive medications from Black Hawk Health Center. ☐ I receive medications from an outside pharmacy.

List any medications/supplements that I get from an outside doctor/pharmacy: _____

_____

Allergies/Intolerance *If yes, describe*

	No	Yes		No	Yes
Acetaminophen	☐	☐	Iodine	☐	☐
NSAIDS	☐	☐	Metals	☐	☐
Codeine/Other Narcotics	☐	☐	Gluten	☐	☐
Penicillin/Amoxicillin	☐	☐	Tree/Pine nuts	☐	☐
Numbing Jelly	☐	☐	Casein	☐	☐
Local Anesthetic	☐	☐	Red Dye/Other Dye	☐	☐
Alcohol/Chlorhexidine	☐	☐	Latex	☐	☐
Sodium Laurel Sulfate	☐	☐	Papaya, Banana, Strawberry, Mint,	☐	☐

Other: _____

Premedication Indications

	No	Yes
Artificial (prosthetic) heart valve	☐	☐
Damaged valves in transplanted heart	☐	☐
Congenital heart disease (CHD)		
Unrepaired, cyanotic CHD	☐	☐
Repaired (completely) in the last 6 months	☐	☐
Repaired CHD w/ residual defects/regurgitation	☐	☐
Did another doctor recommended that you take antibiotics prior dental treatment?	☐	☐

If yes, what type of doctor: _____

Doctor's name: _____

Substance Use

	No	Yes
Do you take/use illicit drugs	☐	☐
Do you use prescriptions recreationally	☐	☐
Do you use tobacco/vape	☐	☐
If yes, are you interested in stopping	☐	☐
Do you drink alcohol	☐	☐

☐Occasional ☐1-2 drinks daily ☐3+ drinks daily

Females Only

	No	Yes
Taking birth control pills	☐	☐
Pregnant *If yes, due date* _____	☐	☐
Nursing a child	☐	☐

Osteonecrosis Risk Factors *If yes, describe and list date of most recent treatment*

	No	Yes
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax, Actonel, Atelvia, Boniva, Reclast, Prolia) for osteoporosis or Paget's disease? _____	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia, Zometa, XGEVA) for bone pain, hypercalcemia, or skeletal complications resulting from Paget's disease, multiple myeloma, or metastatic cancer? _____	☐	☐
Have you had radiation to the head and neck? _____	☐	☐

_____ _____

Patient/Legal Guardian Signature Date Dentist Signature Date