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 ☐Dental aids ☐Water Flosser ☐Toothpicks ☐Other _____
What type of **mouthwash** do you use? ☐Biotene ☐Listerine/Act ☐Therabreath ☐None ☐Other _____

What do you **drink regularly** other than water? *(check 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 (moves)	☐	☐	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 _____	☐	☐
Hypertension (high blood pressure) _____	☐	☐	GERD/Ulcers/Acid Reflux _____	☐	☐
Heart Disease _____	☐	☐	Liver disease/Cirrhosis _____	☐	☐
Glaucoma _____	☐	☐	Kidney disease/Dialysis _____	☐	☐
Hemophilia/Anemia (bleeding disorders) _____	☐	☐	Chronic pain/pain management _____	☐	☐
Autoimmune disorders _____	☐	☐	Lung conditions _____	☐	☐
Cancer _____	☐	☐	Asthma _____	☐	☐
Diabetes _____	☐	☐	Sinus trouble _____	☐	☐
HIV/AIDS/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.

☐ I take blood thinning medication (Aspirin, Plavix/Clopidogrel, Eliquis/Apixaban, Xarelto/Rivaroxaban, etc.).

Medications/supplements 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 before 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	☐	☐
☐Occasionally ☐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