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 ☐Coffee (plain/black) ☐Coffee (add sweetener) ☐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 _____	☐	☐	Joint Replacement _____	☐	☐
Heart Attack _____	☐	☐	Seizures/Epilepsy/Fainting _____	☐	☐
Hypertension (high blood pressure) _____	☐	☐	Frequent vomiting _____	☐	☐
Heart Disease _____	☐	☐	GERD/Ulcers/Acid Reflux _____	☐	☐
Pacemaker _____	☐	☐	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 _____	☐	☐
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 reguarly take opioids/narcotics for pain management.	☐ I take daily oral contraceptives (birth control pills).
☐ I take blood thinning medication (**Aspirin**, **Plavix/Clopidogrel**, **Eliquis/Apixaban**, **Xarelto/Rivaroxaban**, etc.).	

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? _____	☐	☐

Allergies/Intolerance *If yes, describe.*

	No	Yes		No	Yes
Gluten (Intolerance, Celiac Disease)_____	☐	☐	Latex _____	☐	☐
Tree/Pine nuts _____	☐	☐	Iodine _____	☐	☐
Casein/Reclast _____	☐	☐	Metals _____	☐	☐
Flavors: Papaya, Banana, Strawberry, Mint, _____	☐	☐	Alcohol/Chlorhexidine _____	☐	☐
Dyes (Red, Blue) _____	☐	☐	Sodium Laurel Sulfate _____	☐	☐
NSAIDs (Aspirin, Ibuprofen, Naproxen) _____	☐	☐	Nitrous Oxide _____	☐	☐
Pain Reliever (Acetaminophen) _____	☐	☐	Narcotics (Codeine, Hydrocodone) _____	☐	☐
Anesthetics (Benzocaine/Esters, Cetacaine, Lidocaine, Septocaine, Mepivacaine) _____	☐	☐			
Antibiotics (Penicillin/Amoxicillin, Clindamycin, Erythromycin/Azithromycin, Sulfonimides) _____	☐	☐			
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, who/why _____		

Substance Use

	No	Yes
I use illicit drugs/prescriptions recreationally.	☐	☐
I use tobacco/vape/marijuana products.	☐	☐
I consume it by ☐Smoking ☐Dip/Chew ☐Eating		
Would you like resources from us to help stop?	☐	☐
I drink alcohol…	☐	☐
☐Occasionally ☐1-2 drinks daily ☐3+ drinks daily		

Females Only

	No	Yes
Pregnant/Possibly Pregnant: *due date* _____	☐	☐
Nursing a child	☐	☐

_____ _____

Patient/Legal Guardian Signature Date Provider Signature Date