BOSTON MOUNTAIN
RURAL HEALTH CENTER, INC.

BMRHC Dental Health History Form

Today's Date_____

Patient Name: First_____ Ml_ Last_____ DOB:_____

Have you ever had to take antibiotics before a dental appointment?_____

Date of last dental exam_____

Have you had or do you have any of the following? (Please check all that apply)

__ Bacterial Endocarditis (SBE)
__ Joint Replacement
__High Blood Pressure
__Heart Disease
__Heart Valve Replacement
__Angina
__Arrhythmia
__Stroke/TIA
__Taking Blood Thinners
__Tuberculosis
__COPD/Emphysema
__Chronic Bronchitis
__Crohn's Disease/ Ulcerative Colitis
__Diabetes
__MRSA
__Kidney Disease
__Sexually Transmitted Disease
__HIV/AIDS
__Viral Hepatitis (A,B,C)
__Liver Disease
__Other:_____

__Organ Transplant
__Cancer
Type:_____

__Radiation therapy
__Chemotherapy
__Autoimmune disorder
__Thyroid disease
__Stomach Ulcers
__Arthritis
__Pregnant/Breast Feeding
__Osteoporosis
__Seizures
__Sleep Apnea
__Allergies
__ADD/ADHD
__ Migraines
__Mental Illness
__ Recreational Drug Use
__ Asthma

If you have marked any of the above, please give more information in the space below.

_____

Please list all medications are you taking: (include prescriptions and over the counter)

_____

Please list any vitamins or herbal supplements:

_____

Are you currently on birth control: _____

Are you currently pregnant, breast feeding, or on birth control? _____

Please list any allergies:

_____

_____

Has there been any major change in your health within the last year? If so, please explain.

_____

_____

Are you being treated by a physician now? Is so please explain.

Date of last medical exam? _____ Reason for exam? _____
Please list all surgeries or hospitalizations (include dates).

_____

_____

Have you had or do you have any of the following dental conditions? (Please check all that apply)

___Gum Disease

___ Bad Breath or unpleasant taste

___ Treatment of consult for braces

___ Dental Anxiety

___ Fever blisters/cold sores

___ Trauma to the face

___Oral Surgery

___ Jaw Pain (TMD)

___Other head or neck pain

___ Gag Easily

___ Other_____

Have you had any problems after prior dental treatment? If so, explain.

_____

_____

Are you currently in pain? If so, explain.

_____

_____

What is your main reason(s) for your visit today?

_____

_____

Patient's printed name: _____
If patient is under 18, Guardian's printed name: _____
Guardian's relationship to patient: _____
Patient/Guardian signature: _____ Date: _____