Time 12:24 PM

Flucke _Associates Dentistry

Health Assessment Form - 4.25.19

Date 11/07/2019

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now? Yes No If yes

Have you ever been hospitalized or had a major operation in the last 5 years? Yes No If yes

Have you ever had a serious head or neck injury? Yes No If yes

Have you ever been diagnosed with cancer? Please specify type, date of diagnosis and current stage of treatment. Yes No If yes

Are you taking any prescribed medications or OTC supplements/medications? Yes No If yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes

Have you ever been treated with intravenous bisphosphonates for a bone condition or cancer? Yes No

Do you use tobacco (cigarettes, cigars, snuff, chew, vape)? Yes No

Do you drink alcoholic beverages? Yes No

Do you use controlled substances? Yes No

Women: Are you...

- Pregnant?
- Nursing?
- Taking oral contraceptives?
- Trying to get pregnant?
- Taking hormone replacement?

Are you allergic to any of the following?

- Aspirin
- Penicillin
- Codeine or other narcotics
- Acrylic
- Metals
- Latex (rubber)
- Sulfa Drugs
- Local Anesthetics
- Barbiturates, sedatives, or sleeping pil
- Hay fever/seasonal
- Animals
- Food
- Iodine

Do you have any other allergies not previously listed? Yes No If yes

Do you have or have you had, any of the following?

- Artificial (prosthetic) heart valve? Yes No
- Previous infective endocarditis? Yes No
- Damaged valves in transplanted heart? Yes No
- Unrepaired cyanotic CHD? Yes No
- Completely repaired CHD in last 6 months Yes No
- Repaired CHD with residual defects? Yes No
- Congenital Heart Disease Yes No

Do you have, or have you had, any of the following?

- Asthma Yes No
- Emphysema Yes No
- Tuberculosis Yes No
- Radiation Treatment Yes No
- Excessive Bleeding Yes No
- Atherosclerosis Yes No
- Damaged heart valves Yes No
- Low blood pressure Yes No
- Pacemaker Yes No
- Anemia Yes No
- Tonsillitis Yes No
- Neurological disorders Yes No
- Autoimmume disease Yes No
- Systemic lupus erythematosus Yes No
- Parathyroid disease Yes No
- Night sweats Yes No
- Persistent swollen glands in neck Yes No
- Severe or rapid weight loss Yes No
- Excessive urination Yes No
- Angina Yes No
- Diabetes Yes No
- Gastrointestinal Disease Yes No
- Ulcers Yes No
- Stroke Yes No
- Hepatitis,jaundice or liver disease Yes No
- Hemophilia Yes No
- Pain in Jaw Joints Yes No
- Mental health disorder Yes No
- Kidney disease Yes No
- Bronchitis Yes No
- Sinus trouble Yes No
- Chemotherapy Yes No
- Cardiovascular disease Yes No
- Chronic pain Yes No
- Congestive heart failure Yes No
- Heart attack Yes No
- High blood pressure Yes No
- Abnormal bleeding Yes No
- High Cholesterol Yes No
- Fainting or seizures Yes No
- Arthritis Yes No
- Rheumatoid arthritis Yes No
- Autism spectrum disorder Yes No
- Osteoporosis Yes No
- Headaches or migraines Yes No
- Sexually transmitted disease Yes No
- Chest pain upon exertion Yes No
- Joint replacement Yes No
- Eating disorder Yes No
- G.E. reflux/persistent heartburn Yes No
- Thyroid disease Yes No
- Glaucoma Yes No
- Epilepsy Yes No
- AIDS or HIV infection Yes No
- Sleep disorder Yes No
- Recurrent infections Yes No
- Attention deficit disorder Yes No

Have you ever had any serious illness not listed above? Yes No If yes

Dental Information

Are your teeth sensitive to cold, hot, sweets or pressure?	Yes No
Does food or floss catch between your teeth?	Yes No
Is your mouth dry?	Yes No
Have you ever had orthodontic treatment (braces)?	Yes No
Have you had any concerns associated with previous dental treatment?	Yes No
Are you currently experiencing dental pain or discomfort?	Yes No
Do you have earaches or neck pain?	Yes No
Do you have any clicking, popping or discomfort in the jaw?	Yes No
Do you clench or grind your teeth or been told that you do?	Yes No
Do you have any sores or ulcers in your mouth?	Yes No
Do you wear dentures or partials?	Yes No
Have you had any periodontal (gum) treatments?	Yes No
Do you participate in active recreational activities?	Yes No
Do you struggle with daytime fatigue?	Yes No
Do you snore?	Yes No
Have you been diagnosed with sleep apnea?	Yes No
Have you been prescribed a CPAP?	Yes No
Do you use a CPAP machine as prescribed?	Yes No

Smile Evaluation

Do you have concerns about the following?

Missing teeth you would like replaced	Yes No
Old fillings you would like replaced	Yes No
Desire for your teeth to be whiter	Yes No
Would you like to discuss options to improve the appearance of your teeth?	Yes No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. I will not hold the dentist or any member of his/her staff responsible for any action they take or do not take because of errors or omissions that I may have made in completion of this form. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____