Scenic Bluffs
COMMUNITY HEALTH CENTERS

Dental Health Review

Name: ______________________________ Date of Birth: ________ Today's Date:________

Have you ever been told you have any of the following conditions?

- ☐ Abnormal bleeding (following tooth extraction or surgery)
- ☐ Acid reflux
- ☐ Addison's Disease
- ☐ ADHD/ADD
- ☐ Anemia
- ☐ Anxiety/Behavioral Health Concerns
- ☐ Angina
- ☐ Ankle swelling
- ☐ Arthritis, rheumatism
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Bruise easily
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Chest pain upon exertion
- ☐ Chronic back/neck/joint pain
- ☐ Congenital heart defect
- ☐ Congestive heart failure
- ☐ COPD
- ☐ Diabetes Type_____
- ☐ Extra pillows when you sleep
- ☐ Glaucoma
- ☐ Gum Disease
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Heart Transplant
- ☐ Hepatitis Type____
- ☐ High Blood Pressure
- ☐ HIV infection/AIDS
- ☐ Infective Endocarditis
- ☐ Joint replacement
  If yes, year________
  Joint replaced________
- ☐ Kidney Disease
- ☐ Learning Disability
- ☐ Liver disease, jaundice
- ☐ Malignant hyperthermia
- ☐ Mental condition
  If yes, type___________
- ☐ Mitral Valve Prolapse
- ☐ Multiple Sclerosis
- ☐ Neurological condition
  If yes, type___________
- ☐ Orthopedic pins/rods/screws
- ☐ Osteoporosis
- ☐ Other cardiovascular conditions
  Describe______________
- ☐ Pacemaker
- ☐ Persistent cough or cough up blood
- ☐ Prosthetic devices/implants
- ☐ Prosthetic Heart Valve
- ☐ Radiation/chemotherapy
- ☐ Rheumatic fever, rheumatic heart disease
- ☐ Seizures
- ☐ Sexually Transmitted disease
- ☐ Shortness of breath after exercise or when lying down
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Vascular disease
- ☐ Other (list below)

OTHER:____

Do you use tobacco products? Yes No

Are you pregnant? Yes No
Are you nursing? Yes No

List past hospitalizations:

Are you ALLERGIC, or have you had any reaction to:

- ☐ No known drug allergies
- ☐ Local anesthetic
- ☐ Penicillin or other antibiotics
- ☐ Sulfa drugs
- ☐ Aspirin or other pain meds
- ☐ Other_______________

List all medications, herbs and supplements that you take.

Do you have a primary medical care provider? ☐ YES ☐ NO

Are you interested in learning how Scenic Bluffs can become your Medical Home? ☐ YES ☐ NO

To the best of my knowledge, the above information is correct.

Signature____ Date________________