Heartland Health Center

Embracing people, inspiring health

a nebraska health+ center

Name:_____ **DOB:**_____

1.	Yes	No	Is your general health good?				
2.	Yes	No	Has there been a change in your health within the last year?				
3.	Yes	No	Have you been hospitalized or had a serious illness in the last three years?				
			If YES, why?				
4.	Yes	No	Are you being treated by a physician now? For what?				
			Physician Name: Phone Number:				
5.			Date of last medical exam: Date of last dental exam:				
HAVE YOU EXPERIENCED:							
6.	Yes	No	Chest pain upon exertion (angina)?	17.	Yes	No	Dizziness?
7.	Yes	No	Swollen ankles?	18.	Yes	No	Ringing in the ear?
8.	Yes	No	Shortness of breath?	19.	Yes	No	Headaches?
9.	Yes	No	Recent weight loss, fever, night sweats?	20.	Yes	No	Fainting spells?
10.	Yes	No	Persistent cough, coughing up blood?	21.	Yes	No	Blurred vision?
11.	Yes	No	Bleeding problems, bruising easily?	22.	Yes	No	Nervous system disorder?
12.	Yes	No	Sinus problems?	23.	Yes	No	Excessive thirst?
13.	Yes	No	Difficulty urinating, blood in urine?	24.	Yes	No	Frequent urination?
14.	Yes	No	Difficulty swallowing?	25.	Yes	No	Dry Mouth?
15.	Yes	No	Diarrhea, constipation, blood in stools?	26.	Yes	No	Jaundice?
16.	Yes	No	Frequent vomiting, nausea?	27.	Yes	No	Joint pain, stiffness?
DO YOU HAVE OR HAVE YOU HAD:							
28.	Yes	No	Congenital heart disease?	40.	Yes	No	Eye diseases?
29.	Yes	No	Heart attack, heart defects?	41.	Yes	No	AIDS/HIV?
30.	Yes	No	Heart murmurs?	42.	Yes	No	Steroid therapy?
31.	Yes	No	Rheumatic fever?	43.	Yes	No	Tumors, cancer?
32.	Yes	No	Stroke, hardening of arteries?	44.	Yes	No	Arthritis, rheumatism?
33.	Yes	No	History of needing an antibiotic premedication?	45.	Yes	No	SLE (Lupus)?
34.	Yes	No	Asthma, TB, emphysema, other lung diseases?	46.	Yes	No	Skin diseases?
35.	Yes	No	Hepatitis A, B, C or D, other liver disease?	47.	Yes	No	Anemia or blood disorder?
36.	Yes	No	Stomach problems, ulcers?	48.	Yes	No	VD (syphilis or gonorrhea)
37.	Yes	No	High blood pressure?	49.	Yes	No	Herpes?
38.	Yes	No	Diabetes?	50.	Yes	No	Thyroid, adrenal disease?
39.	Yes	No	Allergies to: drugs, foods, medications, latex?	51.	Yes	No	Seizures?

Please list any allergies, diseases or medical problems NOT listed on this form?

Please list:

DO YOU HAVE OR HAVE YOU EVER HAD:							
52.	Yes	No	Psychiatric care?	57.	Yes	No	Hospitalization?
53.	Yes	No	Radiation treatments?	58.	Yes	No	Blood transfusions?
54.	Yes	No	Chemotherapy?	59.	Yes	No	Surgeries?
55.	Yes	No	Prosthetic heart valve?	60.	Yes	No	Pacemaker?
56.	Yes	No	Artificial joint?	61.	Yes	No	Addiction?

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Name:_____				DOB:_____			
ARE YOU TAKING:							
62.	Yes	No	Recreational drugs?	65.	Yes	No	Tobacco in any form?
63.	Yes	No	Drugs, medications, over-the-counter medicines	66.	Yes	No	Alcohol?
			including aspirin, natural remedies?	67.	Yes	No	Bisphosphonates?
64.	Yes	No	Blood thinners?				
LIST MEDICATIONS:							
WOMAN ONLY:							
69.	Yes	No	Are you or could you be pregnant or nursing?	70.	Yes	No	Are you taking birth control pills?

How often do you floss? _____ How often do you brush? _____

Reasons for today's visit _____

_____

Former Dentist: _____ City/State: _____

Please Circle Yes or No for all that apply					
Yes	No	Lip or cheek biting	Yes	No	Fingernail biting
Yes	No	Bad Breath	Yes	No	Food collecting between teeth
Yes	No	Bleeding gums	Yes	No	Foreign objects
Yes	No	Blisters on lips or gums	Yes	No	Are you in pain now
Yes	No	Gums swollen	Yes	No	Mouth breathing
Yes	No	Jaw pain	Yes	No	Mouth pain, brushing
Yes	No	Grinding teeth	Yes	No	Orthodontic treatment
Yes	No	Dental anxiety	Yes	No	Pain around ear
Yes	No	Have you had problems with prior dental treatment?	Yes	No	Periodontal treatment
Yes	No	Burning sensation on tongue	Yes	No	Sensitivity to cold
Yes	No	Chews on one side of mouth	Yes	No	Sensitivity to heat
Yes	No	Chew or smokes	Yes	No	Sensitivity to sweets
Yes	No	Clicking or popping jaw	Yes	No	Sensitivity when biting
Yes	No	Dry mouth	Yes	No	Sore or growth in mouth
		Have you had problems with prior dental treatment? If YES, why?	Yes	No	Loose teeth or broken filling
		Signature:			**Date:**