Dental Group at Reston Station

Health Information

Patient Name: _____ Date: _____
Last First MI

☐ Male ☐ Female Date of Birth: _____ Date of Last Dental Visit/Cleaning: _____/_____

Reason for today's visit: _____

Have you ever had any of the following? Please circle Yes or No.

Y / N	Arthritis	Type: _____
Y / N	Artificial joint	Type: _____ Date: _____
Y / N	Asthma	
Y / N	Abnormal bleeding after a dental procedure	
Y / N	Autoimmune disorders	
Y / N	Bleeding/blood disorders	Type: _____
Y / N	Blood transfusions	
Y / N	Cancer(s)	Type: _____ Date: _____
Y / N	Chemotherapy or Radiation treatment	Date: _____
Y / N	Cortisone or Steroid treatment	Date: _____
Y / N	Dementia	Type: _____
Y / N	Diabetes	Type: _____
Y / N	Drug - alcohol addiction/dependency/abuse	
Y / N	Emphysema	
Y / N	Epilepsy or Seizures	
Y / N	GERD/REFLUX	
Y / N	Heart condition	a) Heart murmur b) Mitral valve prolapse c) Artificial heart valve/Endocarditis/Angina/CHF
Y / N	Heart surgery	Type: _____ Date: _____
Y / N	Hepatitis	Type: _____
Y / N	High blood pressure	
Y / N	High cholesterol	
Y / N	HIV positive or Acquired Immune Deficiency Syndrome, Herpes, HPV or other STD: _____	
Y / N	Kidney problem	Type: _____ Dialysis: _____
Y / N	Leukemia	
Y / N	Liver problem	
Y / N	Organ transplants	Type: _____ Date: _____
Y / N	Currently pregnant	How many weeks: _____
Y / N	Nursing	
Y / N	Osteoporosis	
Y / N	Neurological disorder	_____ Headaches: _____
Y / N	Psychiatric treatment	
Y / N	Rheumatic fever or Scarlet fever	
Y / N	Stroke	
Y / N	Thyroid problem	Type: _____
Y / N	Tobacco use	Type: _____ How much: _____ How long: _____
Y / N	Tuberculosis	Date: _____
Y / N	Other: _____	

Drug allergies or reactions? Please circle Yes or No.

Y / N	Amoxicillin/Penicillin	Y / N	Clindamycin	Y / N	Metals
Y / N	Aspirin or aspirin compounds	Y / N	Latex allergy	Y / N	Tetracycline
Y / N	Codeine or Demerol	Y / N	Local anesthesia (epinephrine sensitive)	Y / N	Other: _____

Please list current medications, vitamins, herbal supplements and the dosage: _____

_____

Are you currently under care of a physician? _____ **Physician's name/number**: _____

Have you been hospitalized in the last 4-5 years? _____

Reason: _____

Do you have any other health conditions that need further clarifications? _____

_____

Turn Over --->

General Health Questionnaire. Please circle Yes or No.

Y / N Have you been diagnosed with Obstructive Sleep Apnea? If Yes, are you using _____ CPAP Machine_____Oral Device
Y / N Do your gums bleed while brushing/flossing? _____
Y / N Have you or a family member ever lost teeth to periodontal disease? _____
Y / N Are you under orthodontic treatment or have had orthodontic treatment in the past? _____
Y / N Do you participate in any sports? _____
Y / N Do you feel any sensitivity to hot, cold, or sweets? _____
Y / N Do you feel any discomfort with chewing? _____
Y / N Are you happy with your smile? _____
Y / N Would you like your teeth whiter? _____
Y / N Do you have or ever had any jaw joint trouble/treatment? If so, by whom_____
Y / N Do you have DRY mouth? _____

EPWORTH SLEEP TEST: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Use the following scale to choose the most appropriate number for each situation.

0 - Would never doze **1** - Slight chance of dozing **2** - Moderate chance of dozing **3** - High chance of dozing

SITUATION: CHANCE OF DOZING

1. Sitting and reading _____
2. Watching television _____
3. Sitting, inactive in a public place _____
4. As a passenger in a car for an hour without a break _____
5. Lying down in the afternoon when circumstances permit _____
6. Sitting and talking to someone _____
7. Sitting quietly after lunch without alcohol _____
8. In a car, while stopped for a few minutes in traffic _____

TOTAL TEST SCORE:

The Epworth Sleepiness Test is a tool, not a diagnosis. However, if your EST score is:

1-6 Obstructive Sleep Apnea is less likely **7-8** Your score is Average
9 or Higher Obstructive Sleep Apnea is more likely.

To the best of my knowledge, all of the information I have provided is accurate/true. If there is a change in my health at future appointments, I will inform the doctor(s) of the change(s).

_____ Date: _____ Doctor's initials: _____
Signature of patient, parent or legal guardian if under 18 years old

OFFICE PRIVACY POLICY

Our office always attempts to protect the privacy of our patients. We do comply with all federal (HIPAA), state and local regulations regarding this issue. A copy of our privacy policy is available on request and is posted in the waiting room for public viewing. Information regarding your care is only shared as a professional necessity; no information is shared for any other reason.

I ACKNOWLEDGE THAT I HAVE SEEN AND/OR RECEIVED A COPY OF THE OFFICE'S PRIVACY POLICY.

_____
Signature of patient, parent or legal guardian if under 18 years old