R.O.A.D.S.
COMMUNITY CARE CLINIC

MEDICAL HISTORY

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Y ☐ N

If YES, please explain: _____

Physician's Name: _____

For WOMEN: Are you taking birth control pills? ☐ Y ☐ N

Are you pregnant? ☐ Y ☐ N If so, expected due date? _____

Are you nursing? ☐ Y ☐ N

Phone # (___) _____ Date of last physical: _____

Do you have, or have you had, any of the following medical conditions? *Please circle YES or NO.*

Y N Abnormal Bleeding
Y N Alcohol / Drug Abuse
Y N Anemia
Y N Arthritis
Y N Artificial Bones / Joints / Valves
Y N Asthma
Y N Blood Transfusion
Y N Cancer / Chemotherapy
Y N Colitis
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Emphysema
Y N Epilepsy
Y N Fainting Spells
Y N Frequent Headaches
Y N Glaucoma
Y N Hay Fever
Y N Heart Attack
Y N Heart Murmur
Y N Heart Surgery
Y N Hemophilia
Y N Hepatitis
Y N Herpes / Fever Blisters
Y N High Blood Pressure
Y N HIV+ / AIDS
Y N Hospitalized for any Reason
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Mitral Valve Prolapse
Y N Pacemaker
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic / Scarlet Fever
Y N Seizures
Y N Shingles
Y N Sickle Cell Disease
Y N Sinus Problems
Y N Stroke
Y N Thyroid
Y N Tuberculosis (TB)
Y N Ulcers
Y N STD

Do you drink alcohol? ☐ Y ☐ N If so, how much? _____

Do you smoke? ☐ Y ☐ N If so, how much? _____

Do you have any disease, condition, or problem not listed previously? ☐ Y ☐ N If so, please describe: _____

Are you allergic, or have you reacted adversely, to any of the following? *Please circle YES or NO.*

Y N Amoxycillin
Y N Aspirin
Y N Codeine
Y N Dental Anesthetics
Y N Erythomycin
Y N Latex
Y N Penicillin
Y N Tetracycline
Y N Other

Please list any other drugs that you are allergic to:

_____

During the past 12 months, have you taken any of the following: *Please circle YES or NO.*

Y N Antiobiotics or sulfa drugs
Y N High blood pressure meds
Y N Insulin, Orinase, or similar med
Y N Digitalis/drugs for heart problems
Y N Cortisone (steroids)
Y N Nonprescription drug / supplements
Y N Anticoagulants
Y N Tranquilizers
Y N Aspirin
Y N Nitroglycerin
Y N Phen-Phen
Y N Other: _____

DENTAL HISTORY

Why did you come to the dentist today? _____

Do you require antibiotics before dental treatment? ☐ Y ☐ N

Have you ever had any unpleasant dental experience? ☐ Y ☐ N

If YES, please explain: _____

_____

Are you apprehensive about dental treatment? ☐ Y ☐ N

How often do you brush? _____

How often do you floss? _____

Do you take fluoride supplements? ☐ Y ☐ N

Do you prefer to save your teeth? ☐ Y ☐ N

Do you gag easily? ☐ Y ☐ N

Do you wear dentures? ☐ Y ☐ N

Does food catch between your teeth? ☐ Y ☐ N

Do you have difficulty in chewing your food? ☐ Y ☐ N

Do you chew on only one side of your mouth? ☐ Y ☐ N

Do you avoid brushing any part of your mouth due to pain? ☐ Y ☐ N

Do your gums bleed easily? ☐ Y ☐ N

Do your gums feel swollen or tender? ☐ Y ☐ N

Have you noticed slow healing sores in your mouth? ☐ Y ☐ N

Are your teeth sensitive to heat, cold, sweet, sour? ☐ Y ☐ N

Do you have popping or clicking in your jaw joint? ☐ Y ☐ N

Do you grind or clench your teeth? ☐ Y ☐ N

Do your jaws ever feel tired or get stuck? ☐ Y ☐ N

Do you have earaches or pain in front of the ears? ☐ Y ☐ N

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Are you unable to open your mouth as far as you want? ☐ Y ☐ N
Are you aware of an uncomfortable bite? ☐ Y ☐ N
Are you a habitual gum chewer or pipe smoker? ☐ Y ☐ N