Patient Name: _____ Date of Birth _____

e-mail: _____ axiUm Chart: _____

GENERAL MEDICAL INFORMATION - PATIENT EVALUATION

Do you have any of the following diseases or problems? [1.3]

- ☐ Active Tuberculosis
- ☐ Persistent cough greater than 3 weeks in duration
- ☐ Cough that produces blood
- ☐ Been exposed to anyone with Tuberculosis
- ☐ No

Have you had any serious illness, operation, or been hospitalized in the past 5 years? [1.6]

- ☐ 0-6 MONTHS
- ☐ 6-12 MONTHS
- ☐ 1-2 YEARS
- ☐ 2-5 YEARS
- ☐ No

Have you ever had any radiation therapy or chemotherapy for a growth, tumor or other condition? [1.11]

- ☐ Radiation
- ☐ Chemotherapy
- ☐ No

Have you had an organ transplant? [1.7]

- ☐ HEART
- ☐ KIDNEY
- ☐ LIVER
- ☐ LUNG
- ☐ OTHER
- ☐ No

Have you had open heart surgery? [1.8]

- ☐ VALVE
- ☐ BYPASS (CABG)
- ☐ OTHER
- ☐ No

Do you use or have you used tobacco (smoking, snuff, chew, bidis)? [1.15]

- ☐ Currently
- ☐ Past
- ☐ Never

Do you drink alcoholic beverages? [1.16]

- ☐ Yes
- ☐ No

Do you use or have you used prescription or street drugs or other substances for recreational purposes? (Cocaine, Ecstasy, Heroin, Marijuana, Methamphetamine, Oxycontin, Other) [1.17]

- ☐ Past
- ☐ Currently
- ☐ Never

FEMALES ONLY

Are you pregnant? [1.18]

- ☐ Yes
- ☐ No

Are you nursing? [1.19]

- ☐ Yes
- ☐ No

Are you taking birth control pills, fertility drugs or hormonal replacement? [1.20]

- ☐ BIRTH CONTROL
- ☐ FERTILITY DRUGS
- ☐ HORMONAL REPLACEMENT

☐ Yes ☐ No **Are you now, or have you been in the past year, under the care of a physician? [1.3]**

☐ Yes ☐ No **Have you ever been told you require premedication prior to dental treatment? [1.9]**

☐ Yes ☐ No **Have you had an orthopedic total joint (e.g. hip, knee, elbow, finger) replacement? [1.10]**

☐ Yes ☐ No **Have you taken, are you taking, or are you scheduled to begin taking Oral bisphosphonates (Alendronate (Fosamax, Fosamax Plus D), Etidronate (Didronel), Ibandronate (Boniva), Risedronate (Actonel), Tiludronate (Skelid))? [1.13]**

☐ Yes ☐ No **Have you taken, are you taking, or are you scheduled to begin taking Intravenous bisphosphonates (Clodronate (Bonefos), Pamidronate (Aredia) or Zoledronic Acid (Reclast, Zometa))? [1.13]**

☐ Yes ☐ No **Have you ever received a pneumococcal vaccine? [1.34]**

☐ Yes ☐ No **Did you receive an influenza immunization between this past October 1 through March 31? [1.34]**

For Marquette University Dental School Staff

Process date _____ Process 1 _____ Process 2 _____ Process 3 _____

MEDICAL CONDITIONS: Do you have or have you had any of the following diseases, problems, or symptoms?

Heart/Blood Pressure problem? [1.21]
- ☐ Rheumatic fever/Rheumatic heart disease
- ☐ Infective endocarditis
- ☐ Congenital heart defect
- ☐ Heart murmur
- ☐ Mitral valve prolapse
- ☐ Angina (chest pain)
- ☐ Heart attack
- ☐ Heart failure
- ☐ Coronary heart disease
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Palpitations
- ☐ Arrhythmia (irregular heart beat)
- ☐ Shortness of breath
- ☐ Swelling of the ankles
- ☐ Pacemaker
- ☐ Implantable defibrillator
- ☐ Other
- ☐ None

Respiratory/Lung problem? [1.22]
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Tuberculosis
- ☐ Sinusitis
- ☐ Bronchitis
- ☐ Persistent cough
- ☐ Sleep apnea
- ☐ Snoring
- ☐ Other
- ☐ None

Diabetes/Endocrine disorder? [1.23]
- ☐ Diabetes – Type 1
- ☐ Diabetes - Type 2
- ☐ Thyroid – Hypothyroidism
- ☐ Thyroid – Hyperthyroidism
- ☐ Other
- ☐ None

Kidney/Urinary disorder? [1.24]
- ☐ Renal failure/insufficiency
- ☐ Dialysis
- ☐ Frequent urination
- ☐ Other
- ☐ None

Neurologic/Nerve problem? [1.26]
- ☐ Stroke
- ☐ TIA (transient ischemic attack)
- ☐ Seizures/Epilepsy
- ☐ Multiple sclerosis
- ☐ Parkinson's disease
- ☐ Neuropathies
- ☐ Dementia/Alzheimer's (memory loss)
- ☐ Headache
- ☐ Fainting or dizzy spells
- ☐ Feeling of tingling or numbness
- ☐ Psychiatric disease/Mental health disorder
- ☐ Bipolar/Manic depression
- ☐ Schizophrenia
- ☐ Depression
- ☐ ADD/ADHD (attention deficit disorder)
- ☐ Feelings of anxiety
- ☐ Feelings of depression
- ☐ Other
- ☐ None

Infectious disease? [1.30]
- ☐ HIV
- ☐ AIDS
- ☐ STD (sexually transmitted disease)
- ☐ Syphilis
- ☐ Gonorrhea
- ☐ Chlamydia
- ☐ Genital herpes
- ☐ Human papillomavirus
- ☐ Cold sores
- ☐ Other
- ☐ None

Muscle/Bone/Connective Tissue disorder? [1.29]
- ☐ Arthritis - Rheumatoid
- ☐ Arthritis - Osteoarthritis
- ☐ Arthritis - Other
- ☐ Osteoporosis
- ☐ Gout
- ☐ Temporomandibular joint disorder
- ☐ Lupus
- ☐ Fibromyalgia
- ☐ Other
- ☐ None

Stomach/Intestine/Liver disorder? [1.28]
- ☐ Cirrhosis/Chronic hepatitis
- ☐ Jaundice (skin/eyes turn yellow)
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Hepatitis D
- ☐ Hepatitis Other
- ☐ Heartburn
- ☐ Acid reflux (GERDS)
- ☐ Ulcers
- ☐ Crohn's disease
- ☐ Other
- ☐ None

Blood/Hematologic disorder? [1.27]
- ☐ Anemia
- ☐ Sickle cell disease
- ☐ Sickle cell trait
- ☐ Bruise easily
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Bleeding disorders – Hemophilia
- ☐ Bleeding disorders - Other
- ☐ Other
- ☐ None

Head/Eye/Ear/Nose/Throat problem? [1.31]
- ☐ Vision problems
- ☐ Glaucoma
- ☐ Hearing impairment
- ☐ Other
- ☐ None

Cancer or Tumors? [1.25]
- ☐ Malignant
- ☐ Benign
- ☐ None

Dermatologic/Skin problem? [1.32]
- ☐ Yes
- ☐ No

Eating disorder? [1.33]
- ☐ Bulimia
- ☐ Anorexia
- ☐ Other
- ☐ None

Do you have any other problem, disease or condition not listed above? [1.34]
- ☐ Yes
- ☐ No

Medications:

In the last 2 years, have you taken or are you now taking steroids (e.g. Cortisone)? [1.12]

If yes, please specify medication(s), dosage/frequency, Length of Period Taken and If no longer taking, when was the medication discontinued.

Steroid Medication	Dosage/Frequency	Length of Period Taken (Days, Weeks, Months, Years)	If no longer taking, when was the medication discontinued?

Are you taking, have you recently (within the last month) taken, or are you supposed to be taking any medications (prescription, over the counter, diet supplements, vitamins, natural or herbal)? [1.1]

Medication	Dosage	Frequency

ALLERGIES

Are you allergic to, or have you had a reaction to any of the following? [1.2]

- ☐ Local anesthetics (Novocaine/Epinephrine) Reaction _____
- ☐ Penicillin Reaction _____
- ☐ Sulfa drugs Reaction _____
- ☐ Other antibiotics Specify _____ Reaction _____
- ☐ Codeine or other narcotics Reaction _____
- ☐ Aspirin Reaction _____
- ☐ Hay fever/seasonal (allergic rhinitis) Reaction _____
- ☐ Metals/Jewelry (nickel/chrome) Reaction _____
- ☐ Food Specify _____ Reaction _____
- ☐ Iodine Reaction _____
- ☐ Latex (rubber) Reaction _____
- ☐ Other/Other Medication(s) Specify _____ Reaction _____
- ☐ None

Please add comments or notes here for medical information not addressed by the above questions. [1.35]

Dental History

What is the reason for your dental visit today? [2.1]

☐ Examination ☐ Emergency ☐ Consultation ☐ Procedure

PAST DENTAL TREATMENT - Have you been to the dentist before? [2.2] ☐ Yes ☐ No

If yes:	0-6 MONTHS	6-12 MONTHS	1-2 YEARS	More than 2 YEARS
How long ago was your last dental visit?	☐	☐	☐	☐
How long ago was your last dental exam?	☐	☐	☐	☐
How long ago was your last dental x-ray	☐	☐	☐	☐
How long ago was your last dental cleaning?	☐	☐	☐	☐

Do you have a history of tooth extraction or oral surgery (implants, cosmetic procedures or TMJ surgery)? [2.3]

- ☐ EXTRACTIONS
- ☐ IMPLANTS
- ☐ FACIAL COSMETICS
- ☐ TMJ SURGERY
- ☐ No

Have you had any periodontal (gum) treatments? [2.4]

- ☐ Yes
- ☐ No

Do you have bridges or wear dentures or partials? [2.5]

- ☐ BRIDGES
- ☐ DENTURES
- ☐ PARTIALS
- ☐ No

Have you ever had root canal treatment? [2.6]

- ☐ Yes
- ☐ No

Have you ever had orthodontic (braces) treatment? [2.7]

- ☐ Yes
- ☐ No

Have you had a local anesthetic (Novocaine) for dental purposes? [2.8]

- ☐ Yes
- ☐ No

Have you had any problems associated with previous dental treatment? [2.9]

- ☐ Yes
- ☐ No

DENTAL PROBLEMS (SIGNS/SYMPTOMS)

Are you currently experiencing dental pain or discomfort? [2.10]

- ☐ Yes
- ☐ No

Are your teeth sensitive to cold, hot, sweets or pressure? [2.11]

- ☐ COLD
- ☐ HOT
- ☐ SWEETS
- ☐ PRESSURE
- ☐ None

Do you have problems with eating (trouble chewing, vomiting, etc)? [2.12]

- ☐ TROUBLE CHEWING
- ☐ VOMITING
- ☐ OTHER
- ☐ No

Do you have swelling in or around your mouth, face or neck? [2.13]

- ☐ MOUTH
- ☐ FACE
- ☐ NECK
- ☐ No

Do you have loose teeth? [2.14]

- ☐ Yes
- ☐ No

Do you have headaches, earaches or neck pains? [2.15]

- ☐ HEADACHES
- ☐ EARACHES
- ☐ NECK PAINS
- ☐ No

Do you have any clicking, popping, discomfort, or limited opening in the jaw? [2.16]

- ☐ CLICKING
- ☐ POPPING
- ☐ DISCOMFORT
- ☐ LIMITED OPENING
- ☐ No

Do you have sores or ulcers in your mouth? [2.17]

- ☐ Yes
- ☐ No

Have you ever had a serious injury to your head or mouth? [2.18]

- ☐ Yes
- ☐ No

Are you unhappy with your smile or the appearance of your teeth? [2.19]

- ☐ Yes
- ☐ No

DENTAL DISEASE PREVENTION (ORAL HYGIENE/DIET)

How often do you brush your teeth? [2.20]

- ☐ SOMETIMES
- ☐ ONCE A DAY
- ☐ TWICE A DAY
- ☐ MORE THAN TWICE A DAY
- ☐ Never

How often do you floss your teeth? [2.21]

- ☐ SOMETIMES
- ☐ ONCE A WEEK
- ☐ ONCE A DAY
- ☐ MORE THAN ONCE A DAY
- ☐ Never

Do your gums bleed when you brush or floss? [2.22]

- ☐ SOMETIMES
- ☐ ALWAYS
- ☐ Never

ORAL HABITS

Do you clench, brux, or grind your teeth? [2.24]

- ☐ CLENCH
- ☐ BRUX/GRIND
- ☐ BOTH
- ☐ None

To the best of my knowledge, I have answered every question completely and accurately.

Patient/Legal Guardian Signature: _____ Date: _____

Patient Name: _____ Date of Birth _____ axiUm Chart: _____

Start each note with question number from health history form.

Patient Name: _____ Date of Birth _____ axiUm Chart: _____

CORAH Dental Anxiety Scale

(Circle one answer for each question)

If you had to go to the dentist tomorrow, how would you feel about it? [4.1]

1. I would look forward to it as a reasonably enjoyable experience.
2. I wouldn't care one way or the other.
3. I would be a little uneasy about it.
4. I would be afraid that it would be unpleasant and painful.
5. I would be very frightened of what the dentist might do.

When you are waiting in the dentist's office for your turn in the chair, how do you feel? [4.2]

1. Relaxed
2. A little uneasy
3. Tense
4. Anxious
5. So anxious that I sometimes break out in a sweat or almost feel physically sick.

When you are in the dentist's chair waiting while he/she gets the drill ready to begin working on your teeth, how do you feel? [4.3]

1. Relaxed
2. A little uneasy
3. Tense
4. Anxious
5. So anxious that I sometimes break out in a sweat or almost feel physically sick.

You are in the dentist's chair to have your teeth cleaned. While you are waiting and the dentist is getting out the instruments which he/she will use to scrape your teeth around the gums, how do you feel? [4.4]

1. Relaxed
2. A little uneasy
3. Tense
4. Anxious
5. So anxious that I sometimes break out in a sweat or almost feel physically sick.

Notes [4.5]

_____

_____

_____

_____

Total Score [4.6] _____

Do you have a disability? [3.1] Yes No

If yes, answer the following questions:

What type of disability do you have? [3.2] _____

How long have you been disabled? [3.3] _____

Does your disability affect you in any of the following functions? [3.4]

A. Bladder/bowel control	Yes	No
B. Breathing	Yes	No
C. Cognitive ability	Yes	No
D. Communication	Yes	No
E. Manual dexterity	Yes	No
F. Sight	Yes	No
G. Sitting position	Yes	No
H. Sitting tolerance	Yes	No
I. Walking	Yes	No

Please explain any yes answers: [3.5] _____

_____

_____

_____

What, if any, assistance do you require from other people? [3.6] _____

_____

Are you able to give informed consent? [3.7] Yes No

Is there anyone who helps you make decisions about your medical and dental treatment? [3.8] Yes No

Name: [3.9] _____

Will an attendant, guardian, or interpreter accompany you to your appointments? [3.10] Yes No

Name: [3.11] _____

For Marquette University Dental School Clinic Use Only

Use this section to record student and faculty signatures designating review and approval of the patient health history for existing patients until the health history is fully incorporated into the electronic health record.

Student signature/ID#: _____ Date: _____

Faculty signature/ID #: _____ Date: _____