PATIENT MEDICAL HISTORY Please print legibly

Salutation	First Name	Last Name	M.I.

Home Phone ( )	Cell Phone ( )	Date of Birth
Work Phone ( )	Fax ( )	Gender

Home Address	City/State/Zip
Employer Name	Occupation
Employer Address	Social Security Number
Referring Doctor	Family Dentist
Family Physician	Family Physician Phone ( )
Guarantor	Date of Last Physical Exam / /
Home E-mail	Work E-mail
Insurance Company	Address

Subscriber's Name	Subscriber's Social Security Number	
Subscriber's DOB	Group #	Relationship

	Yes	No	Don't Know
1. Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth? If yes, please explain.			
2. Has there been any change in your general health within the past year? If yes, please explain.			
3. Are you under the care of a physician for a current problem? If yes, explain.			
4. Have you been hospitalized within the past 5 years? Please specify.			
5. Are you taking any medication or drugs? Please list them below.			
6. Have you received therapy for alcoholism or drug addiction during the past 5 years?			
7. Have you ever had any ALLERGIC or ADVERSE REACTIONS to anesthetics/antibiotics/ medications?			
8. Is there any condition concerning your health that the doctor should be told?			
9. Do you wish to speak to the doctor privately about anything?			
10. Have you had abnormal bleeding with previous extractions, surgery, or trauma?			
11. Have you ever required a blood transfusion?			
12. Have you ever had surgery and/or radiation for a tumor, growth, or other condition?			
13. Have you ever tested positively for HIV infection or AIDS? If so, state date diagnosed and treating doctor.			
14. Are you required to take antibiotics prior to dental treatment?			
15. Women only: are you pregnant, nursing or on birth control pills?			

Please continue

☐	Chest pain, angina	☐	Irregular heart beat
☐	Swollen ankles, arthritis or joint disease	☐	Contagious diseases
☐	Cardiac pacemaker	☐	Bronchitis, chronic cough
☐	Heart surgery	☐	Hay fever or sinus problems
☐	Delay in healing	☐	Problems with the immune system
☐	Tuberculosis	☐	Difficult breathing or other lung trouble
☐	Emphysema	☐	Chronic fatigue or night sweats
☐	X-Ray treatment or chemotherapy	☐	History of drug abuse
☐	On a diet	☐	Wear contact lenses
☐	History of alcohol abuse	☐	Bruise easily
☐	Eye disease or glaucoma	☐	Gallbladder trouble
☐	Infectious mononucleosis	☐	None of the above

	Yes	No	Don't Know
16. Are you taking any herbal medicine (i.e., St. John's Wort)?			
17. Have you ever taken the "fen-phen" diet?			
18. Do you have any disease, condition or problem not listed above? Specify.			

Please continue:

Women only:

Possibility of pregnancy: YES / NO	Nursing: YES / NO
Estimated delivery date:	Taking birth control pills: YES / NO

NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/ gynecologist for assistance regarding additional methods of control.

Injury:

This visit is related to an accident YES / NO	Work related: YES / NO
Date of injury:	
Insurance company handling the claim:	
Claim Number:	

Please list all medications and dosages below:

Medication	Dosage	Frequency	Reason for Taking

COVID-19 Screening questions

Do you have a fever or have you recently felt feverish? □ Yes □ No

Do you have a cough? □ Yes □ No

Are you having shortness of breath or any difficulty breathing? □ Yes □ No

Do you have any chills or repeated shaking with chills? □ Yes □ No

Do you have any recent onset of headache or sore throat? □ Yes □ No

Do you have any other flu-like symptoms? □ Yes □ No

If yes please explain:

____

____

Have you experienced any recent GI upset or diarrhea? □ Yes □ No

Are you in contact with anyone who has been diagnosed or tested positive with COVID-19? □ Yes □ No

Have you been tested and received a positive test result for COVID-19? □ Yes □ No

If yes, when: ____

Have you been diagnosed with COVID-19? □ Yes □ No

Have you travelled outside of Vermont in the past 14 days? □ Yes □ No

Pain History Questions

1) Have you experienced pain in this tooth at any time in the past?

   □ Yes □ No

2) Are you in pain now?

   □ Yes □ No

   If no, please skip to question #19

3) If you are in pain, how long have you been in pain?

   □ 1 day □ 2-3 days
   □ 4-5 days □ 1 week/Longer

4) Did the pain keep you awake or awaken you last night?

   □ Yes □ No □ No, but it has in the past

5) Can you locate the tooth that is causing the pain?

   □ Yes □ No □ Not sure
   □ It may be more than one tooth

6) Does the pain radiate to other parts of your jaw or down your neck and shoulders?

   □ Yes □ No
   □ Not now, but it has in the past

7) Is the pain spontaneous or does it always require some stimulus to become painful?

   □ I have spontaneous pain
   □ It always takes some stimulus to make the tooth hurt
   □ I don't have spontaneous pain now, but I have in the past

8) Do you feel swollen now? □ Yes □ No

9) Has there been a history of prior swelling? □ Yes □ No

10) Are you running a fever? □ Yes □ No

11) How would you rate the severity of your pain today?

1 = Very Slight and 10 = Unbearable __________

12) Do you have lingering pain (lasting more than a few seconds)?

□ Yes □ No

13) Please check the frequency and nature of pain that most closely describes your discomfort (check all options that apply to your case):

□ Sharp □ Dull □ Radiating □ Throbbing
□ Migrating □ Constant □ Aching □ Intermittent
□ Gnawing □ Variable □ Enlarging to Other Areas
□ Shooting □ Tingling □ Itching □ Momentary
□ Burning □ Only when chewing or biting

14) Is the tooth sensitive to temperature?

□ Yes □ No
□ Not now, but it has in the past

15) What relieves the pain (check all options that apply to your case)?

□ Nothing □ Cold □ Hot □ Tylenol
□ NSAIDs □ Advil/Alieve □ Antibiotics
□ Avoiding the area □ Massage □ Narcotics (opioids)

16) If you don't touch the tooth or bite on it, does it still hurt?

□ Yes □ No □ Sometimes
□ Not now, but it has in the past

17) What increases the pain (check all options that apply to your case)?

□ Touching □ Biting □ Cold
□ Cold Air □ Hot □ Lying Down
□ Eating □ Sweets □ Pressing on gum
□ Flossing □ Nothing

18) What is the course of the pain?

□ Increasing □ Decreasing □ Constant
□ Variable (comes and goes) □ None now

19) Has there been any recent restorative work (fillings/crowns) done in this area?

□ Yes □ No

20) Prior to this appointment has endodontic treatment (root canal) been started on this tooth by any doctor?

□ Yes □ No

21) Have you had recent periodontal (gum) surgery in the area?

□ Yes □ No

22) Have you ever had an endodontic surgery (apicoectomy) on this tooth?

□ Yes □ No

23) Are you numb now (been given anesthesia earlier today)?

□ Yes □ No

24) Have you taken any antibiotics for this problem?

□ Yes □ No

If yes what kind? ______________________

25) Have you taken any painkillers for this problem?

□ Yes □ No

____ ______________________

Patient Signature (Parent signature if patient is under 18 years of age). Date