Portland Community College®

PCC Dental Clinic

Patient Health History Form

Although dental personnel primarily treat the area in and around your mouth, it's important to remember that your mouth is part of your whole body. Existing health conditions or medications you are taking could have an important interrelationship with the dentistry you will receive. Thank you for taking the time to answer the following questions.

Full Name:_____ Date of Birth:_____

Preferred Name: _____

Emergency contact name, relationship, and phone number: _____

_____

What are your preferred pronouns?

- ☐ He/Him/His
- ☐ She/Her/Hers
- ☐ They/Them/Theirs
- ☐ Other:_____

MEDICAL HISTORY:

1. Are you under a physician's care now?

- ☐ Yes - Name of Physician: _____
- ☐ No

2. Are you taking any medications or supplements, either prescribed or over the counter?

- ☐ Yes
- ☐ No

If yes, please list them, and what they are taken for: _____

_____

_____

_____

_____

3. Have you ever been hospitalized or had a major operation?

- ☐ Yes
- ☐ No

If yes, why/when? _____

_____

4. Have you ever had a serious head or neck injury?

- ☐ Yes
- ☐ No

If yes, what happened/when? _____

_____

5. Do you have any physical or psychological challenges that need to be accommodated for?

- ☐ Yes
- ☐ No

If yes, how can we accommodate? _____

_____

6. Are you taking a blood thinner or anti-clotting medication?

- ☐ Yes
- ☐ No

If yes, what and when was your most recent INR? _____

_____

7. Have you ever taken or are scheduled to take a bisphosphonate medication, oral or IV, such as Fosomax, Boniva, Actonel, Zometa, Aredia, Didronel, etc, or other bone-strengthening medications for osteoporosis, Paget's disease, or other bone disease?

- ☐ Yes - If yes, which one? _____
- ☐ No

8. Do you use nicotine?

- ☐ Yes - What form and how often? _____
- ☐ No

9. Have you used nicotine in the past?

- ☐ Yes - What form and when did you quit? _____
- ☐ No

10. Do you use Marijuana/THC?

- ☐ Yes - What form and how often? _____
- ☐ No

1**1.** Do you use any other controlled substances?

- ☐ Yes - What and how often? _____
- ☐ No

12. Do you use alcohol on a daily basis?

- ☐ Yes - What and how many per day? _____
- ☐ No

13. Are you on a special diet?

☐ Yes - What type of diet? _____

☐ No

14. Have you had an organ transplant or bone marrow/stem cell transplant?

☐ Yes

☐ No

If yes, what and when? _____

_____

15. If it is possible for you to become pregnant, are you….

O Pregnant/trying to get pregnant **O** Nursing **O** Taking oral contraceptives

If pregnant, how many weeks and when are you due? _____

16. Are you allergic to any of the following:

O No Allergies	**O** Local Anesthetics	**O** Seasonal Allergies
O Penicillin	**O** Metals	**O** Iodine/Shellfish
O Codeine	**O** Latex	**O** Sodium Laurel Sulfate
O Sulfa Drugs	**O** Aspirin	**O** Adhesive

O Other _____

17. Have you ever had an anaphylaxis reaction or needed an epi-pen?

☐ Yes

☐ No

Do you have or have you had any of the following? Mark all that apply.

18. Chronic Infectious Diseases

AIDS/HIV positive	**O** Yes **O** No	Hepatitis A	**O** Yes **O** No
Hepatitis C	**O** Yes **O** No	Cold sores/ Oral HPV	**O** Yes **O** No
Tuberculosis	**O** Yes **O** No	Pneumonia	**O** Yes **O** No
Hepatitis B	**O** Yes **O** No	MRSA or VRSA	**O** Yes **O** No

19. Cardiac and Circulatory Health

Angina/chest pains	**O** Yes **O** No	Damaged heart valve	**O** Yes **O** No
High cholesterol	**O** Yes **O** No	High blood pressure	**O** Yes **O** No
Heart attack	**O** Yes **O** No	Pacemaker/Implanted device	**O** Yes **O** No
Coronary artery bypass (CABG) or other heart surgery	**O** Yes **O** No	Coronary artery disease/ Arteriosclerosis	**O** Yes **O** No
Congenital heart defect (repaired or unrepaired)	**O** Yes **O** No	Rheumatic fever/rheumatic heart disease	**O** Yes **O** No
Arrhythmia/irregular heart beat	**O** Yes **O** No	Tachycardia (rapid heart rate)	**O** Yes **O** No
Swelling of limbs	**O** Yes **O** No	History of endocarditis	**O** Yes **O** No
Stroke	**O** Yes **O** No	Other cardiac or circulatory condition	**O** Yes **O** No
Artificial (prosthetic) heart valve	**O** Yes **O** No	Mitral valve prolapse	**O** Yes **O** No
Low blood pressure	**O** Yes **O** No	Recent carotid endarterectomy or stenting	**O** Yes **O** No
Congestive heart failure	**O** Yes **O** No	Transitory Ischemic Attack (TIA)	**O** Yes **O** No
Atrial fibrillation (Afib)	**O** Yes **O** No		

20. Respiratory Health

Asthma	**O** Yes **O** No	Emphysema	**O** Yes **O** No
Cough that produces blood	**O** Yes **O** No	Persistent or frequent cough	**O** Yes **O** No
COPD	**O** Yes **O** No	Sleep Apnea	**O** Yes **O** No
Shortness of breath/ Easily winded	**O** Yes **O** No	Recent upper respiratory infection (covid, flu, cold, or RSV)	**O** Yes **O** No
Bronchitis	**O** Yes **O** No	Oxygen dependence	**O** Yes **O** No
Other breathing problem	**O** Yes **O** No		

21. Kidney and Genitourinary Health

Kidney disease	**O** Yes **O** No	Kidney failure	**O** Yes **O** No
Frequent urination	**O** Yes **O** No	STI/STD	**O** Yes **O** No
Gall or kidney stones	**O** Yes **O** No	Other kidney or genito-urinary condition	**O** Yes **O** No

22. Head, Neck, and Musculoskeletal Health

Orthopedic joint replacement (knee, hip, shoulder, etc)	**O** Yes **O** No	Osteoporosis	**O** Yes **O** No
Glaucoma	**O** Yes **O** No	Macular degeneration	**O** Yes **O** No
Tonsilitis	**O** Yes **O** No	Upper cervical/neck pain or care	**O** Yes **O** No
Impairment of hearing, sight, or speech	**O** Yes **O** No	Other head, neck or musculoskeletal condition	**O** Yes **O** No
Sinus problem	**O** Yes **O** No		

23. Hormone Health

Diabetes type I	**O** Yes **O** No	Diabetes type II	**O** Yes **O** No
Hypoglycemia	**O** Yes **O** No	Hyperthyroidism	**O** Yes **O** No
Adrenal disease such as Cushing's	**O** Yes **O** No	Grave's or Hashimoto's disease	**O** Yes **O** No
Hypothyroidism	**O** Yes **O** No	Hormone replacement therapy	**O** Yes **O** No
Other hormone deficiency or excess	**O** Yes **O** No	Gender affirming care/hormone therapy	**O** Yes **O** No
Gestational diabetes	**O** Yes **O** No	Metabolic syndrome	**O** Yes **O** No
Other hormone related condition	**O** Yes **O** No		

24. Neurological Health

Fainting spells or dizzy episodes	**O** Yes **O** No	Epilepsy	**O** Yes **O** No
Parkinson's disease	**O** Yes **O** No	Tremors	**O** Yes **O** No
Alzheimer's disease	**O** Yes **O** No	Dementia	**O** Yes **O** No
Concussion	**O** Yes **O** No	ADHD/ADD	**O** Yes **O** No
Tourette's syndrome	**O** Yes **O** No	Cerebral Palsy	**O** Yes **O** No
Other nervous system disorder	**O** Yes **O** No	Traumatic brain injury	**O** Yes **O** No
Seizures or convulsions	**O** Yes **O** No	Autism spectrum disorder	**O** Yes **O** No
Frequent headaches or Migraines	**O** Yes **O** No	Developmental or intellectual disability	**O** Yes **O** No

25. Autoimmune Health

Crohn's disease	**O** Yes **O** No	Ulcerative colitis	**O** Yes **O** No
Ehler's Danlos	**O** Yes **O** No	Multiple Sclerosis	**O** Yes **O** No
Chronic fatigue syndrome	**O** Yes **O** No	Rheumatoid arthritis or other inflammatory arthritis	**O** Yes **O** No
Cushing's syndrome	**O** Yes **O** No	History of cortisone medication	**O** Yes **O** No
Immune deficiency or immunocompromised	**O** Yes **O** No	POTS (postural orthopedic hypertension)	**O** Yes **O** No
Other autoimmune disorder	**O** Yes **O** No	Addison's disease	**O** Yes **O** No
Lupus	**O** Yes **O** No	Hives or rash	**O** Yes **O** No
Sjogren's syndrome	**O** Yes **O** No	Fibromyalgia	**O** Yes **O** No

26. Mental Health

Generalized anxiety	**O** Yes **O** No	Clinical depression	**O** Yes **O** No
PTSD	**O** Yes **O** No		

Are you currently being treated for any mental health condition?

- ☐ Yes: _____
- ☐ No

Do you have or have you previously been treated for drug dependency?

- ☐ Yes
- ☐ No

27. Blood Health & Conditions

Anemia	**O** Yes **O** No	Hemophilia	**O** Yes **O** No
Blood transfusion	**O** Yes **O** No	Sickle cell disease	**O** Yes **O** No
Other blood condition	**O** Yes **O** No	Excessive or prolonged bleeding	**O** Yes **O** No
Bruise easily	**O** Yes **O** No		

28. Stomach, Liver, Intestinal Health

Stomach Ulcer	**O** Yes **O** No	Acid Reflux/GERD	**O** Yes **O** No
Frequent vomiting	**O** Yes **O** No	Malnutrition	**O** Yes **O** No
Cirrhosis of the liver	**O** Yes **O** No	Jaundice	**O** Yes **O** No
Irritable bowel syndrome	**O** Yes **O** No	Other liver, stomach, intestinal disease	**O** Yes **O** No
Heartburn	**O** Yes **O** No	Bile duct disease	**O** Yes **O** No
Eating Disorder	**O** Yes **O** No		

29. Cancer

Cancer	**O** Yes **O** No	Chemotherapy treatment	**O** Yes **O** No
Radiation treatment	**O** Yes **O** No	Non-cancerous tumor or growth	**O** Yes **O** No

If yes to cancer, please list type of cancer, date of diagnosis, and date of treatment:

_____

_____

_____

DENTAL HISTORY:

30. Do you have or have you had any of the following? Mark all that apply.

Bleeding gums	**O** Yes **O** No	Sensitivity to hot, cold, sweets, or pressure	**O** Yes **O** No
Periodontal (gum) treatment such as SRP or deep cleaning	**O** Yes **O** No	Needed to be numb for dental cleaning in the past	**O** Yes **O** No
Night guard for grinding or clenching	**O** Yes **O** No	Mandibular advancement device for snoring or sleep apnea	**O** Yes **O** No
Dental implants	**O** Yes **O** No	Oral surgery	**O** Yes **O** No
Gum graft or other periodontal surgery	**O** Yes **O** No	Trouble chewing	**O** Yes **O** No
Pain in jaw joint	**O** Yes **O** No	Dry mouth	**O** Yes **O** No
Trouble opening mouth widely	**O** Yes **O** No	History of jaw locking open or closed	**O** Yes **O** No

Bleeding gums	**O** Yes **O** No	Sensitivity to hot, cold, sweets, or pressure	**O** Yes **O** No
Bad breath	**O** Yes **O** No	Extraction (removal of teeth)	**O** Yes **O** No
History of, or current orthodontic treatment	**O** Yes **O** No	Clenching or grinding	**O** Yes **O** No
Dentures or partial dentures	**O** Yes **O** No	Dental fear or anxiety	**O** Yes **O** No
Used whitening trays or had teeth whitened	**O** Yes **O** No	Mouth breathing	**O** Yes **O** No

31. What is the reason for your dental visit today? _____

_____

32. Are you currently in any dental pain or discomfort?

- ☐ Yes
- ☐ No

33. If yes, please describe

_____

_____

34. Do you have any sores in or around your mouth?

- ☐ Yes
- ☐ No

35. Name of current/most recent dentist: _____

36. Date of last dental visit: _____

37. Date of last x-rays and type: _____

38. Date of last dental cleaning: _____ Type of cleaning: _____

39. Have you ever had any problems or difficulties following dental treatment?

- ☐ Yes - Explain:_____
- ☐ No

40. Have you ever taken an antibiotic premedication prior to dental treatment?

- ☐ Yes (Type:_____)
- ☐ No

41. Have you ever had a bad or unusual reaction to dental anesthesia?

- ☐ Yes
- ☐ No

42. Have you ever had a severe injury to your face, teeth, or jaw?

- ☐ Yes
- ☐ No

43. Have you ever had surgery or procedures on your mouth or lips, including lip or cheek fillers or botox:

- ☐ Yes
- ☐ No

44. How often do you brush your teeth? _____

45. How often do you floss your teeth? _____

46. Do you use fluoridated toothpaste or fluoride supplements? _____

47. Please state any concerns you have about your dental care: _____

_____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____

SIGNATURE **DATE**