Complete Health Dentistry of Portland

ADULT ORAL AND SYSTEMIC HEALTH HISTORY

Our purpose is to improve the health of all patients. We believe you want a healthy mouth and a healthy body. Let us partner with you for both.

Name_____ Date of Birth_____ Today's Date_____

What is your most important concern today? _____

Caries (tooth decay):

Do you consider yourself cavity prone? ..... **Y N**
Do you consume sugary foods or beverages on a regular basis? ..... **Y N**
Do you consume any citrus flavored beverages? ..... **Y N**
Does your mouth feel dry? ..... **Y N**
Do you have heartburn or reflux? ..... **Y N**

Periodontal Disease:

Have you been told you have gingivitis or gum disease in the past? ..... **Y N**
Do your gums ever bleed when you brush or floss? ..... **Y N**
Do you have gum recession or exposed root surfaces? ..... **Y N**
Do you have any loose teeth, drifting teeth, or areas that collect food when you eat? ..... **Y N**

Oral Cancer:

Do you have any persistent sore spots on your mouth or lumps/bumps in your head or neck? ..... **Y N**
Do you feel as if you have a lump in your throat..... **Y N**
Recognizing that HPV infection is the single biggest risk factor for oral/pharyngeal cancer, do you want a saliva test to see if you are at risk? ..... **Y N**
Women: Do you have two or more alcohol drinks per day average? ..... **Y N**
Men: Do you have three or more alcohol drinks per day average? ..... **Y N**
Are you a current smoker? **Y N** Packs per day _____?
Are you a former smoker? **Y N** When did you quit? _____
Chronic exposure to second hand smoke? ..... **Y N**
Are you currently chewing tobacco? ..... **Y N**
If so, how much? _____
Interested in quitting? ..... **Y N**
Are you a former chewer? **Y N** When did you quit_____?
Do you use recreational drugs? ..... **Y N**

Medical Care:

Please list all health care providers on last page.

Are you currently being treated for any medical conditions? ..... **Y N**
Do you wish you felt better cared for or more trusting of your medical team? ..... **Y N**
Do you seek annual prevention services? ..... **Y N**

General Health:

How would you rate your overall health?
1 (poor)- 10 (excellent) ..... _____
How important is health to you?
1 (not at all) – 10 (highest priority) ..... _____
Has your health changed in the past year? ..... **Y N**
Any serious illness or hospitalizations in the past five years? ..... **Y N**
Any chronic ongoing or recurrent illness? ..... **Y N**

Gender Health:

Female:

Are pregnant or planning pregnancy? ..... **Y N**
Taking birth control pills? ..... **Y N**
Are you nursing? ..... **Y N**
In menopause? ..... **Y N**

Male:

Erectile dysfunction? ..... **Y N**

Vital Measurements:

Weight _____
Height _____
Are you satisfied with your weight? ..... **Y N**
Is your waist measurement more than 40 inches (men) or 35 inches (women)? ..... **Y N**

Function/Bite/TMJ Dysfunction

Do you have any missing teeth other than wisdom teeth? ..... **Y N**

Do you ever experience discomfort when chewing... **Y N**

Do your jaw joints click, pop or make grinding sounds?..... **Y N**

Do you experience frequent headaches or jaw/facial pain?..... **Y N**

Do your joints ever get stuck or locked?..... **Y N**

Have you ever been treated for a jaw joint problem? ..... **Y N**

If so, by what methods:

Do you wear any removable dentures of partial dentures? ..... **Y N**

If so, are they comfortable and well-fitting? ..... **Y N**

Cardiovascular Health:

Are you currently being treated for high blood pressure or cardiovascular disease?..... **Y N**

Have you had any heart valves replaced? ..... **Y N**

Do you have a history of heart attack, stroke, bypass surgery or stents?..... **Y N**

Do you experience shortness of breath or chest pain?..... **Y N**

Do you have a family history of heart disease? ..... **Y N**

Do you take anti-cholesterol medicine? ..... **Y N**

Have you ever been diagnosed or treated for high blood pressure? ..... **Y N**

If so, is it currently controlled? ..... **Y N**

Do you currently take blood pressure medicine? ..... **Y N**

Do you monitor your own blood pressure? ..... **Y N**

PreDiabetes and Diabetes:

Have you ever been diagnosed with prediabetes or diabetes? ..... **Y N**

Do you take medications for diabetes?..... **Y N**

What was your last HgA1c number? ..... _____

Do you have any biologic family members with diabetes? ..... **Y N**

Do your gums bleed when you brush or floss?..... **Y N**

Cancer:

Do you have a cancer diagnosis or history? ..... **Y N**

Are you currently undergoing cancer treatment? .. **Y N**

Do you currently have a suspicion or fear of cancer in your body? ..... **Y N**

Do you have any known risk factors for a specific cancer? ..... **Y N**

Brain Health:

Have you been diagnosed with dementia, depression, anxiety disorder or any other brain function aliment? ..... **Y N**

Do you frequently feel sad, energy depleted or anxious? ..... **Y N**

Have you lost interest in activities that used to make you happy? ..... **Y N**

Do you experience "brain fog" where your awareness of surroundings seems dulled?..... **Y N**

Do you have difficulty remembering names or words you want to use? ..... **Y N**

Do you frequently forget where you put your keys or phone or how to get from place to place? ..... **Y N**

Other Organ Dysfunction:

Are you aware of or being treated for any vital organ disease such as diseases of the thyroid, lungs, liver, kidneys, uterus, pancreas or brain? .... **Y N**

Dependency/Addiction:

Are you currently in recovery or being treated for addiction? ..... **Y N**

Do you smoke or chew tobacco? ..... **Y N**

If yes, do you want to quit? ..... **Y N**

Do you depend on any prescription or non-prescription drugs to sleep, wake or relieve pain?... **Y N**

Do you consume caffeine in excess of three 8-ounce servings a day? ..... **Y N**

Do you feel you are addicted to any sugar? ..... **Y N**

Sleep:

Do you or your partner:

Ever snore? ..... **Y N**

Experience interruptions in breathing during sleep?..... **Y N**

Have difficulty sleeping? ..... **Y N**

Feel tired or fatigued during the day? ..... **Y N**

Have a sleep study history? ..... **Y N**

Have a CPAP or oral sleep appliance? ..... **Y N**

Joints:

Do you have joint inflammation, pain or arthritis? .. **Y N**

Have you had a history of joint surgery or joint replacement?..... **Y N**

Nutrition and Lifestyle

How would you rate your nutrition/diet?
1 (poor)-10 (excellent) …….. _____
Do you have any eating disorders? …… **Y N**
Do you take dietary supplements? …….. **Y N**
Do you snack frequently?…… **Y N**
Do you have gum, mints, or cough drops regularly?…… **Y N**
Are you open to receiving information or help regarding nutrition? …… **Y N**
Do you follow a special diet? …… **Y N**
Do you aspire to make changes to your diet? ……. **Y N**
Do you desire a change in weight? …… **Y N**
What sugary foods or drinks do you consume regularly?

List any other beverages you consume on a regular basis:

Do you exercise regularly? ……**Y N**
If so, how many times per week? _____
If so, what do you currently do for exercise?

Do you have exercise goals you hope to achieve? …**Y N**

Pharmacology:

Please list all medications you are currently taking, including prescription and over-the-counter (OTC) medications, vitamins and supplements **on the last page**.

If easier, attach list of medications and dosages.

Do you have a desire to reduce the amount of medication you currently take? ……**Y N**

Bone Health:

Have you been diagnosed with Osteopenia or Osteoporosis? …… **Y N**
Have you had an abnormal bone density test? ….. **Y N**
Have you been treated with oral or injectable medications for Osteoporosis? ……. **Y N**
Do you suspect Vitamin D deficiency? …… **Y N**

Allergies, Food Sensitivities, and Other Chronic Inflammatory Conditions:

Are you aware of any chronic inflammatory conditions such as irritable bowel syndrome, fibromyalgia, arthritis, chronic fatigue syndrome, insulin resistance, or periodontal/gum disease? ……**Y N**
If so, please list or circle.

Are you aware of any allergies, including medications? ……**Y N**
If so, please list.

Do you have asthma? ……**Y N**
If yes, what triggers an attack?

If yes, has your asthma changed in the past two years?

Have you identified any food sensitivities such as dairy, wheat or soy? …… **Y N**
Do you suffer from GI disturbance such as discomfort, bloating, constipation or diarrhea? ……**Y N**
Do you ever have heartburn or regurgitation? ……**Y N**
Do you have difficulty losing weight despite considerable effort? ……**Y N**
Do you regularly eat foods that make you feel sluggish, sick or guilty? ……**Y N**
Do you have red patches, itchy skin, or itchy ears? …**Y N**

Is there a condition not listed or anything else you would like us to know?

Medications, vitamins and supplements with dosages:

Please list all of your health care providers including their address and phone contact information.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that this is the way to ensure the best care possible. I will inform Complete Health Dentistry of Portland of any changes in my health status.

Signature: _____ Date: _____