

# Dental/Medical History Update

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Patient Name: (please print)		Age:
Address:		
Dawg Tag Number:	Phone Number:	Email:

## Medical History Update

1. Has there been any change in your health since your last dental appointment? Yes  No
2. If so, what \_\_\_\_\_
3. Are you taking any kind of medication (including over-the-counter) at this time? Yes  No
4. If so, list with dosages \_\_\_\_\_
5. Have you developed any new allergies or sensitivities? Yes  No
6. If so, what (i.e. medications, latex, metals) \_\_\_\_\_

## Dental History Update

1. Please list any dental pain, problems, or concerns: \_\_\_\_\_
2. How often do you visit your dentist? Twice a year  Once a year  Rarely or Never
3. How often do you brush your teeth each day? 2-3 times  1 time  Less than 1 time
4. How often do you floss your teeth? Everyday  3-4 times per week  Rarely or Never
5. Do you use fluoride toothpaste? Yes  No
6. Have you had cavities in the past? Yes  No
7. How long has it been since your last cavity? More than 24 months/Never  12-24 months  Less than 12 months
8. How many times daily do you eat sugary foods between meals? Only with meals  1-2 times  3 or more
9. Do you wear braces, orthodontic appliances, or partial dentures? Yes  No
10. Does your mouth often feel dry (not enough saliva)? Yes  No
11. Do you have special care needs limiting your ability to care for your teeth and gums? Yes  No
12. Do you use chewing gum, mints, or other products that contain (sugar-free) Xylitol? Yes  No
13. Have you had sealants placed on your teeth? Yes  No
14. Do you have a history of jaw joint (TMJ) disorder? Yes  No
15. Do dental treatments cause you much concern, worry, or make you tense? Yes  No
16. When was your last dental exam? \_\_\_\_\_ dental cleaning? \_\_\_\_\_ xrays? \_\_\_\_\_

Questions #2-13 Cavity Risk Assessment. Copyright 2009 CIGNA. All rights reserved. Reproduced by SIUC with permission of CIGNA.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

The information I have provided is accurate to the best of my knowledge.