



University of Pittsburgh

University Dental Health Services, Inc.

UPMC Montefiore Hospital
Suite 202 South
3459 Fifth Ave
Pittsburgh, PA 15213
412-648-6730
Fax: 412-648-6505

Main Office
Suite 3189 Salk Hall
3501 Terrace Street
Pittsburgh, PA 15261
412-648-9100
Fax: 412-383-9829

Oral Surgery
Suite G32
412-648-8604
Fax: 412-648-3600

Dental and Medical History

Patient Name: _____ Date: _____

Primary reason for this dental appointment: Examination Emergency Consultation

Dental History *(please check yes or no)*

Do you have a specific dental problem? Yes No
Describe: _____

Do you have dental examinations on a routine basis? Yes No
Date of Last Visit: _____

Do you think you have active decay or gum disease? Yes No
Discuss: _____

Do you brush and floss on a routine basis? Yes No
Discuss: _____

Do your gums ever bleed? Yes No
Discuss: _____

Do you like your smile? Yes No
Why? _____

Does food catch between your teeth? Yes No

Do you have any loose teeth? _____

Do you want to keep your remaining teeth? Yes No
Discuss: _____

Do you ever have clicking, popping or discomfort in the jaw joint? Yes No
Discuss: _____

Do you brux or grind? Yes No
Discuss: _____

Have your past experiences in a dental office always been positive? Yes No
Discuss: _____

Do you smoke or chew? Do you have any sores in your mouth? Yes No
Discuss: _____

Name of previous dentist (optional) _____

Date of last full mouth x-rays (16 small films or panoramic): _____

Date of last bitewing x-rays (looks for cavities between teeth): _____



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Dental and Medical History

Medical History *(please check yes or no)*

Patient Name: _____ Date: _____

Home Phone: _____ Business/Cell Phone: _____

Birthdate: _____ Gender: M F

Are you under a physician's care now? Yes No

Why? _____ Who? _____ Phone? _____

Have you ever been hospitalized or had a major operation? Yes No

Discuss _____

Are you taking any medications, pills, or drugs? Yes No

What? _____

Are you on a special diet? Yes No

Discuss _____

Do you use tobacco products? Yes No

How Often? _____

Do you drink alcohol Yes No

How Often? _____

Are you allergic to any medications or substances? _____ Yes No

Please check box below:

Aspirin Penicillin Codeine Acrylic Metal Latex Rubber

Other _____

Women *(please check all that apply)*

Pregnant/trying to get pregnant Nursing Taking oral contraceptives

Do you now have or have you ever had any of the following? *(please check appropriate boxes)*

	Yes/No		Yes/No		Yes/No
Heart Trouble/Disease	<input type="checkbox"/> <input type="checkbox"/>	Bloody Sputum	<input type="checkbox"/> <input type="checkbox"/>	Stroke	<input type="checkbox"/> <input type="checkbox"/>
Heart Murmur	<input type="checkbox"/> <input type="checkbox"/>	Fainting or Dizziness	<input type="checkbox"/> <input type="checkbox"/>	Glaucoma	<input type="checkbox"/> <input type="checkbox"/>
Angina/Chest Pain	<input type="checkbox"/> <input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/> <input type="checkbox"/>	Emphysema	<input type="checkbox"/> <input type="checkbox"/>
Heart Attack	<input type="checkbox"/> <input type="checkbox"/>	Nervousness	<input type="checkbox"/> <input type="checkbox"/>	Tuberculosis	<input type="checkbox"/> <input type="checkbox"/>
Congenital Heart Disorder	<input type="checkbox"/> <input type="checkbox"/>	Bruise or Bleed Easily	<input type="checkbox"/> <input type="checkbox"/>	X-Ray Treatment (<i>Radiation</i>)	<input type="checkbox"/> <input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/> <input type="checkbox"/>	Anemia	<input type="checkbox"/> <input type="checkbox"/>	Chemotherapy	<input type="checkbox"/> <input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/> <input type="checkbox"/>	Sickle Cell Disease	<input type="checkbox"/> <input type="checkbox"/>	Stomach/Intestinal Disease	<input type="checkbox"/> <input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/> <input type="checkbox"/>	Hemophilia (<i>Bleeding Problems</i>)	<input type="checkbox"/> <input type="checkbox"/>	Recent Weight Loss/Gain	<input type="checkbox"/> <input type="checkbox"/>
Heart Pace Maker	<input type="checkbox"/> <input type="checkbox"/>	Leukemia	<input type="checkbox"/> <input type="checkbox"/>	Stomach Ulcers	<input type="checkbox"/> <input type="checkbox"/>
Coronary Stent	<input type="checkbox"/> <input type="checkbox"/>	Mouth Ulcers	<input type="checkbox"/> <input type="checkbox"/>	Frequent Diarrhea	<input type="checkbox"/> <input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/>	Recent Blood Transfusion	<input type="checkbox"/> <input type="checkbox"/>	Diabetes	<input type="checkbox"/> <input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/> <input type="checkbox"/>	Lung Disease	<input type="checkbox"/> <input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/> <input type="checkbox"/>
Blood Disease	<input type="checkbox"/> <input type="checkbox"/>	Swelling of Limbs	<input type="checkbox"/> <input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/> <input type="checkbox"/>
Alcoholism	<input type="checkbox"/> <input type="checkbox"/>	Breathing Problem	<input type="checkbox"/> <input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/> <input type="checkbox"/>
Liver Disease	<input type="checkbox"/> <input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/> <input type="checkbox"/>	Drug Addiction	<input type="checkbox"/> <input type="checkbox"/>
Yellow Jaundice	<input type="checkbox"/> <input type="checkbox"/>	Frequent Cough	<input type="checkbox"/> <input type="checkbox"/>	Tumors or Growths	<input type="checkbox"/> <input type="checkbox"/>
Cold Sores	<input type="checkbox"/> <input type="checkbox"/>	Asthma	<input type="checkbox"/> <input type="checkbox"/>	Allergies (<i>Pollen/Dust</i>)	<input type="checkbox"/> <input type="checkbox"/>
HIV+/AIDs	<input type="checkbox"/> <input type="checkbox"/>	Immuno Compromised	<input type="checkbox"/> <input type="checkbox"/>	Fever Blisters/Herpes	<input type="checkbox"/> <input type="checkbox"/>
CD4 count _____		Venereal Disease	<input type="checkbox"/> <input type="checkbox"/>	Genital Herpes	<input type="checkbox"/> <input type="checkbox"/>
Hives or Rash	<input type="checkbox"/> <input type="checkbox"/>	Kidney Problems	<input type="checkbox"/> <input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/> <input type="checkbox"/>
Parathyroid Disease	<input type="checkbox"/> <input type="checkbox"/>	Arthritis/Gout	<input type="checkbox"/> <input type="checkbox"/>	Pain in Jaw Joints	<input type="checkbox"/> <input type="checkbox"/>
Cortisone/Steroids	<input type="checkbox"/> <input type="checkbox"/>	Artificial Joint	<input type="checkbox"/> <input type="checkbox"/>	Epilepsy	<input type="checkbox"/> <input type="checkbox"/>
Hepatitis A (<i>Infectious</i>)	<input type="checkbox"/> <input type="checkbox"/>	Hepatitis B or C	<input type="checkbox"/> <input type="checkbox"/>	Convulsions/Seizures	<input type="checkbox"/> <input type="checkbox"/>

Need Medication B/F Dental Appt.

