INDIANA UNIVERSITY
NORTHWEST

MEDICAL HISTORY

Name: **D.O.B:** **AGE:**

If you are completing this form for another person, what is your relationship to that person?
Your Name: ____ **Relationship:**____________________________

Physician name:____ **Physician phone number:**_________________

PLEASE ANSWER THE FOLLOWING QUESTIONS BY INDICATING YES OR NO:

Question		
Are you in good health?	Yes	No
Has there been any change in your general health within the past year?	Yes	No
Are you under a physician's care or currently under medical treatment? If yes, describe:____ ____	Yes	No
Have you been hospitalized/had major surgery/serious illness in the last five years? If yes,describe:____ ____	Yes	No
Have you ever had excessive bleeding following an extraction, or had other bleeding problems?	Yes	No
WOMEN: Are you or could you be pregnant? Due date: / /	Yes	No
WOMEN: Are you nursing?	Yes	No
WOMEN: Do you take hormonal replacement medications?	Yes	No
Do you take any prescriptions and/or over the counter medications? If yes, list all dosages and frequency of medications taken, including vitamins, natural/herbal preparations and/or diet supplements: ____ ____ ____ ____ ____	Yes	No
Do you use tobacco in any form? Vaping? If yes, in what form and how much: ____ ____ If you use tobacco/vaping, how interested are you in stopping? (Circle one) Very Interested/Somewhat Interested/Not Interested	Yes	No
Do you consume alcoholic beverages (more than two drinks a day)?	Yes	No
Do you use recreational drugs? Do you use painkillers (opioids)?	Yes	No
Have you taken Fosamax, Bonvia, Actonel, or medications containing bisphosphonates?	Yes	No
Has any physician or dentist recommended that you take antibiotics prior to dental treatment? If yes, for what?	Yes	No

ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO:

Local Anesthetics	Yes	No	Barbiturates/sedatives/sleeping pills	Yes	No
Penicillin or other antibiotics	Yes	No	Sulfa	Yes	No
Aspirin	Yes	No	Codeine/other narcotics	Yes	No
Latex (rubber)	Yes	No	Food If yes, what?	Yes	No
Any other allergies If yes, describe:				Yes	No

DO YOU HAVE ANY OF THE FOLLOWING DISEASES OF PROBLEMS?

Active tuberculosis	Yes	No	Cough that produces blood	Yes	No
Persistent cough greater than a 3 week duration	Yes	No	Been exposed to anyone with tuberculosis	Yes	No

***THIS FORM MUST BE COMPLETED ANNUALLY** **Revised 07/2023**

MEDICAL HISTORY CONTINUED

PLEASE CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT THE PRESENT:

AIDS/HIV	**ALCOHOLISM**	**ALZHEIMER'S/DEMENTIA**
ANAPHYLAXIS	**HIVES/RASH**	**CONVULSIONS**
EXCESSIVE THIRST	**FAINTING/DIZZINESS**	**FREQUENT HEADACHES/MIGRAINES**
GASTROESOPHAGEAL REFLUX	**GLAUCOMA**	**HEARTBURN**
HERPES (COLD SORES/BLISTERS)	**HIGH CHOLESTEROL**	**HYPERGLYCEMIA/HYPOGLYCEMIA**
RECENT WEIGHT LOSS/GAIN	**SHINGLES**	**SINUS PROBLEMS**
SPINA BIFIDA	**STEROID THERAPY**	**SWELLING OF LIMBS**
SYSTEMIC LUPUS ERYTHEMATOSUS	**TONSILLITIS**	**TUBERCULOSIS**
TUMORS/GROWTHS		
ARTHRITIS If yes, specify below: Osteoarthritis Rheumatoid	**ARTIFICIAL JOINT(S)** If yes, specify: ___________________________________ PREMEDICATION? YES/NO ___________________________________	**BLOOD ABNORMALITIES** If yes, specify below: Abnormal/Excessive Bleeding, Anemia, Bruise Easily, Hemophilia, Sickle Cell Disease, Thrombocytopenia, von Willebrand's Disease, Other: ___________________________________ INR/PT Number:
CANCER If yes, specify what type of cancer: ______________________________________ Radiation Treatment Chemotherapy	**CARDIOVASCULAR DISEASE** If yes, specify below: Angina, Arteriosclerosis, Congestive Heart Failure, Damaged Heart Valves, Mitral Valve Prolapse, Valve Replacement, Pacemaker, Heart Attack Date:_____ /____/______, Heart Murmur, Rheumatic Fever,Defibrilator Chest Pain Upon Exertion, Congenital Heart Conditions, Low/High Blood Pressure, Other:_____________________________	**CEREBROVASCULAR DISEASE** If yes, specify below: Aneurysm, Stroke Date: ____/_____/__________ Transient Ischemic Attack (TIA) Other: ___________________________________
DIABETES If yes, specify below: Type I (Insulin dependent) Type II	**EATING DISORDERS** If yes, specify below: Anorexia Nervosa, Bulimia Other:	**EPILEPSY or a SEIZURE DISORDER** If yes, specify below: Other
GASTROINTESTINAL DISEASE If yes, specify below: Crohn's Disease, Irritable Bowel Syndrome (IBS) Other: _______________________________	**HEPATITIS/JAUNDICE/LIVER DISEASE** If yes, specify type of Hepatitis: ___________________________________	**KIDNEY PROBLEMS** If yes, specify below: Dialysis Days: _____________________________ Glomerulonephritis, Kidney Stones, Other:
MENTAL HEALTH/PSYCHIATRIC CARE If yes, specify:_________________________ Post-Traumatic Stress Disorder(PTSD) Anxiety, Depression, Bi-Polar Disorder	**ORGAN TRANSPLANT** If yes, specify organ:_____________________________ Date of Transplant: ___________________________________	**RESPIRATORY DISEASE** If yes, specify below: Asthma, Breathing Problems/Easily Winded, Bronchitis, COPD, Cystic Fibrosis, Emphysema, Frequent Cough, Hayfever, Other:
SEXUALLY TRANSMITTED INFECTIONS (STIs) If yes, specify below: Chlamydia, Genital Herpes, Genital Warts, Gonorrhea, Human Papilloma Virus, Syphilis, Other: ________________________	**THYROID DISEASE** If yes, specify below: Goiter, Hyperthyroidism (Grave's Disease), Hypothyroidism, Parathyroid Disease, Other:_____________________	**Vitals:** **Blood Pressure: / Right/Left** **Temp:_____** **Resp:______** **Pulse:______**

Please list any diseases, conditions or medical problems not listed above:

____

I have reviewed the information on this medical history and it is accurate to the best of my knowledge. I understand this information will be used by the IUN Dental Education Clinic to determine appropriate dental treatment.
If there is any change in my medical status, I will inform the IUN Dental Education Clinic.

DATE: ____/_____/ _______	**STUDENT SIGNATURE:** ____
PATIENT/GUARDIAN SIGNATURE: ______________________________________	**FACULTY SIGNATURE:** ____

INDIANA UNIVERSITY
NORTHWEST

DENTAL HISTORY

Patient Name:	D.O.B. :	Age:

Date of last dental visit: / /	Date of last cleaning: / /	Date of last x-rays: / /

How often do you visit a dentist?	How often do you have your teeth cleaned?
Dentist's Name: (First and Last)	Dentist's Phone #:

DO YOU CURRENTLY HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING:

Gum Disease	Yes	No	Injuries to Jaw/Head/Neck	Yes	No
Loose Teeth	Yes	No	Dry Mouth	Yes	No
Bleeding/Sore Gums	Yes	No	Shifting of Teeth/Change in Bite	Yes	No
Bleeding when Brushing or Flossing	Yes	No	Unpleasant Taste/Bad Breath	Yes	No
Clicking/Popping/Pain in Jaw	Yes	No	Biting Cheeks/Lips	Yes	No
Burning Tongue/Lips	Yes	No	*Periodontal Treatment/Gum Surgery	Yes	No
Swollen/Painful Gums	Yes	No	*Oral Surgery	Yes	No
Difficulty/Pain upon Opening Jaw	Yes	No	*Orthodontic Treatment/Braces	Yes	No
Clenching/Grinding	Yes	No	*Endodontic Treatment/Root Canal	Yes	No
Frequent Blisters or Cold Sores	Yes	No	*Treatment for TMJ Problems	Yes	No
Sensitivity to Cold/Sweets/Pressure	Yes	No	Chewing Difficulty	Yes	No
Change in Occlusion/Bite	Yes	No	Food Lodging Between Teeth	Yes	No
*Please Explain:					

DO YOU HAVE ANY OF THE FOLLOWING HABITS?

Grind/Clench Teeth	Yes	No	Bite Fingernails	Yes	No
Mouth Breathing While Awake/Sleep	Yes	No	Hold Objects with Teeth	Yes	No

DENTAL INFORMATION:

Do you wear dentures/partials?	Yes	No	If yes, specify:
Do you drink bottled/filtered water?	Yes	No	If yes, how often?
Is your water supply fluoridated?	Yes	No	
Have you had any problems associated with previous dental treatment?	Yes	No	If yes, please explain:

DO YOU USE THE FOLLOWING?

Toothbrush (Soft, Medium, or Hard)	Yes	No	How often do you brush?
Dental Floss	Yes	No	How often do you floss?
Fluoride Rinse	Yes	No	What type and how often?
Other Dental Aids	Yes	No	If yes, what type?
WHAT ARE YOUR DENTAL CONCERNS?			

To the best of my knowledge, the above information is complete and correct.

Date:	**Patient Signature:**	**Faculty Signature:**	**Student Signature:**

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