ICMS
COMPASSIONATE COLLABORATIVE COMMUNITY CARE

Patient Name: _____

Age: _____ Date: _____

Your answers are for our records only and will be confidential except where disclosure is required by law.

Special Considerations:

CURRENT BP _____/_____ **TEMP:** _____

MEDICAL QUESTIONS:

1.	Have there been any changes in your health in the past year?	Y	N
2.	Are you under the care of a physician?	Y	N
3.	Have you had any serious illnesses or operations?	Y	N
4.	Have you ever taken weight-loss medication?	Y	N
5.	Females: Are you pregnant?	Y	N

Explain any 'yes' answers: _____

---

6. Please check if you have (or have had) any of the following problems:

☐ AIDS / HIV Positive
☐ Anemia
☐ Arthritis
☐ Artificial heart valve(s)
☐ Artificial joint(s)
☐ Asthma
☐ Back problems
☐ Blood disease
☐ Cancer
Describe_____
☐ Chemo/radiation therapy
☐ Circulation problems
☐ Cortisone treatments
☐ Cough, persistent or bloody

☐ Diabetes
☐ Emphysema

☐ Epilepsy
☐ Fainting
☐ Food allergies
☐ Headaches, frequent/severe
☐ Hearing loss

☐ Heart murmur
☐ Heart, any problems
Describe _____
☐ Hemophilia
☐ Herpes
☐ Hepatitis A B C D
☐ High blood pressure
☐ Jaundice
☐ Jaw pain
☐ Kidney disease
☐ Liver disease
☐ Low blood pressure
☐ Mitral valve prolapse

☐ Nervous problems
☐ Pacemaker

☐ Psychiatric care
☐ Respiratory disease
☐ Rheumatic fever
☐ Seizure disorders

☐ Shingles
☐ Shortness of breath
☐ Sinus problems
☐ Skin rash
☐ Stroke
☐ Surgical implants
☐ Swelling, feet or ankles
☐ Thyroid problems
☐ Tuberculosis
☐ Ulcers/colitis/acid reflux
☐ Vision Impairment
☐ Other
Describe_____

_____

☐ **NONE OF THESE**

7. Allergies/Sensitivity:

☐ Anesthetic
☐ Aspirin
☐ Penicillin
☐ Codeine
☐ Sulfa
☐ Iodine
☐ Latex
☐ Nickel
☐ Other _____
☐ **NONE OF THESE**

8. List any medications (prescription, non-prescription, and/or vitamins) you are currently taking:

_____
_____
_____
_____

9. Pre-medication required before dental treatment? Y N

Prescribing Physician _____

Dosage/Time taken_____

10. Travel within last 30 days? Y N

If yes, where: _____

DENTAL QUESTIONS:
Please circle the appropriate answer for each condition/disease.

1. Have you had any serious problem(s) with any previous dental treatment? Y N
2. Have you ever had an injury to your face, jaw, or teeth? Y N
3. Do you ever feel like you have a dry mouth? Y N
4. Have you ever had an unusual reaction to local anesthetic (numbing)? Y N
5. Do you wear full or partial dentures? Y N
6. Have you had any teeth replaced with a dental implant(s)? Y N
7. Have you had any teeth replaced with a fixed bridge(s)? Y N
8. Have you ever had any of the following treatment(s)?
   - ☐ Gum/periodontal treatment Y N
   - ☐ Orthodontics (braces) Y N
   - ☐ Endodontics (root canal) Y N
   - ☐ Extractions (teeth removed) Y N
   - ☐ Bleaching/whitening Y N
9. Do you have any piercings in the head and neck area? Y N

If yes, when were they done?_____ Where is/are the piercings?_____

Explain any yes answers:_____

_____

Check if you have any problems with the following:

☐ Bad breath	☐ Food trapped between teeth	☐ Sensitivity to cold
☐ Bleeding, sensitive gums	☐ Grinding or clenching teeth	☐ Sensitivity to hot
☐ Canker sore or cold sores	☐ Loose teeth	☐ Sensitivity to sweets
☐ Clicking or popping jaw: right or left	☐ Broken fillings	☐ Sensitivity to biting
	☐ Periodontal treatment	☐ Staining

10. Do you smoke or use tobacco in any form? Y N

What kind? _____ How frequently? _____

How long? _____ Would you like to quit? _____

The answers to the questions listed above are accurate. I understand this information will be used to determine the dental treatment I receive in this dental office and may be shared with other medical offices only as necessary. I will notify this dental office should any information change. I hereby authorize this dental office to perform recommended services.

Signature of Patient, or parent if a minor: _____ Date_____

LAST REVIEWED BY PATIENT AND DENTAL TEAM MEMBER: (IF MORE THAN 2 YEARS, COMPLETE NEW FORM)

PT. INITIALS: _____ PT. INITIALS: _____ PT. INITIALS: _____

STAFF: _____ STAFF: _____ STAFF: _____

DATE _____ DATE: _____ DATE: _____