AccessPointe
Community Health Centers

**Section I: Patient Information Date_____**

**Name:_____ I prefer to be called: _____**

Date of Birth:_____ Email Address_____

Spouse or Parent's Name:_____

**Section II Medical History**

**Is your current physical health: Good_____Fair_____Poor_____**

**Do you currently have a primary care physician/provider? Yes_____No _____**

**Date you last saw your primary care physician/provider _____**

**Name and contact number of primary care physician/provider _____**

**For Women: Are you pregnant? Yes_____No_____ Are you nursing? Yes_____No_____**

Are you using a prescribed method of birth control? Yes_____No_____

Do you smoke or use tobacco in any other form? Yes_____ No_____# Packs_____

Have you had any metal rods, pins or implants? Yes_____No_____Where/when placed?_____

Are you taking any prescription/over-the-counter or herbal supplemental drugs? Yes_____ No_____

List of Medicines:_____

Past Surgeries and Dates:_____

Have you ever taken Fosamax or any other bisphosphonate (prescription Calcium supplement)? Yes____No____

**Have you ever had any of the following diseases or medical problems?**

| | | | |
|---|---|---|---|
| Y or N Abnormal Bleeding | Y or N Epilepsy/Seizures | Y or N High Blood Pressure | Y or N Rheumatic Fever |
| Y or N Alcohol/Drug Abuse | Y or N Fainting Spells | Y or N HIV/AIDS | Y or N Scarlet Fever |
| Y or N Anemia | Y or N Frequent Headaches | Y or N Kidney Problems | Y or N Shingles |
| Y or N Arthritis | Y or N Glaucoma | Y or N Liver Disease | Y or N Sickle Cell Disease |
| Y or N Artificial Bones | Y or N Hay Fever | Y or N Low Blood Pressure | Y or N Sinus Problems |
| Y or N Artificial Joints | Y or N Heart Attack | Y or N Lupus | Y or N Stroke |
| Y or N Artificial Heart Valve | Y or N Heart Murmur | Y or N Mitral Valve Prolapse | Y or N Thyroid Problems |
| Y or N Cancer | Y or N Heart Surgery | Y or N Osteoporosis/Paget's | Y or N Tuberculosis |
| Y or N Congenital Heart Defect | Y or N Hemophilia | Y or N Pacemaker | Y or N Ulcers |
| Y or N Diabetes | Y or N Hepatitis | Y or N Psychiatric Problems | Y or N Venereal Disease |
| Y or N Emphysema | Y or N Herpes | Y or N Radiation/Chemotherapy | Y or N Asthma |

**Are you allergic to any of the following?**

| | | | |
|---|---|---|---|
| Y or N Aspirin | Y or N Dental Anesthetics | Y or N Latex | Y or N Tetracycline |
| Y or N Codeine | Y or N Erythromycin | Y or N Penicillin | Y or N Other |

**OTHER CONDITION OR ALLERGY NOT LISTED ABOVE? _____**

**Section III Dental History**

**Is your current dental health: Good_____Fair_____Poor_____ Do you like your smile? Yes_____No_____**

**Do you require antibiotics before any dental treatment is performed? Yes_____No_____**

What is you chief complaint and why are you here today?_____

Are you currently in pain? Yes_____No_____Are your teeth sensitive to temperature or pressure? YesNo_____

Have you ever had a serious or difficult problem associated with any previous dental work? Yes No____ Have you ever had a gum treatment? Yes_____No_____Do your gums ever bleed? Yes_____No _____

Do you or have you ever experienced pain/discomfort in your jaw joint? (TMJ/TMD) Yes_____No _____

How many times a week to you floss your teeth?_____ Brush your teeth? _____

What type of bristles are on your toothbrush? Soft_____ Medium_____Hard _____

How long do you use a toothbrush before replacing it? _____

Have you ever lost any teeth? Yes_____No_____, why? _____

Signature of Patient or Parent_____Date_____