**Midtown Health Center- Dental Clinic**

**HEALTH QUESTIONAIRE**

NAME: (NOMBRE): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH: (FECHA DE NACIMIENTO) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CHIEF COMPLAINT -Why are you seeking dental care? : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(QUEJAS- POR QUE BUSCA UN CUIDADO DENTAL) : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently under the care of a physician /Esta usted bajo el cuidado de un doctor? Yes No

Please list your family physician and any medical specialists you see at least once a year: (please print)

Por favor mencione su doctor de familia y cualquier especialista medico que frecuenta por lo menos una vez al a $ño?$

Name Address City Phone# Name of Specialist

Nombre Dirección Ciudad Teléfono Nombre del especialista

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

Circle Marque

Below: abajo

**Yes No** **Do you have (or have you ever had) any of the following?** *Tiene ud (o ha tenido) cualquiera de los sigu.*

1. **Allergic reaction to drugs or latex (circle all that apply)** *Reaccion a alguno de estos (marque el que aplique)*

**Latex Penicillin Aspirin Codeine Local Anesthetics Other**

*Látex Penicilina aspirina codeína anestésicos otros*

**Yes No** b. Heart attack or heart disease *Paro cardiaco o enfermedades Del Corazon*

**Yes No** c. Stroke Ataques

**Yes No** d. High Blood Pressure *Alta Presion*

**Yes No** e. Congestive heart failure *Falla del Corazon Congestiva*

**Yes No** f. Angina (Chest Pain) *Dolor de Pecho*

**Yes No** g. Irregular heart beat *Latidos de Corazon iregulares*

**Yes No** h. Artificial heart valve *Valvula artificial del corazón*

**Yes No** I. Rheumatic fever, rheumatic heart disease,  *Fiebre reumática, enfermedad de Corazón reumático,*

 bacterial endocarditis *bacteria que pertenezca al Corazón.*

**Yes No** j. Congenital Heart disease *Enfermedad congenita al corazón*

**Yes No** k. Heart murmur or mitral valve prolapse *Murmullo en el corazon o prolapso dela valvula mitral*

**Yes No** l. Immunosuppressive condition (circle all that apply) *Condicion imunosupresivas (marque todo el que aplique)*

Steroid therapy (e.g. prednisone) Radiation or Cancer therapy SLE (Lupus) Rheumatoid Arthritis HIV Organ Transplant Spleen Removed Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Terapia de esteroides Radiaciones o terapia para el cancer Lupus Artritis reumatica VIH Transplante de organos bazos removidos Otros\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Yes No** m. Artificial joint(s) (circle all that apply) *Tendons artificiales (marque todo el que aplique)*

 Hip (cadera) Knee(rodillas) Ankle (tobillos) Shoulder (Hombros)

 Dates placed (Fechas) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Yes No** n. Other artificial implants or devices *otros inplantes articifiales o devicibles*

**Yes No** o. Bleeding problem, anemia, *sangrados, anemia,*

 other blood disease  *u otras enfermedades de la Sangre*

**Yes No** p. Diabetes *Diabetis*

**Yes No** q. Thyroid diseases *tyroides*

**Yes No** r. Long term antibiotic use *Uso de antibiotic por largo plazo*

 (greater than one month continuously) *(mas de un mes continuo)*

**Yes No** s. Nervous system disease or seizures *problemas del sistema nervioso o ataques*

**Yes No** t. Kidney disease  *problemas de los Ri*$ñones$

**Yes No** u. Hepatitis (A,B,C, or D) or other liver disease. *Hepatitis (A,B,C,o D) u otros problemas del Higado*

**Yes No** v. Muscle or joint disease or arthritis  *Coyonturas o artritis*

 (osteo or rheumatoid) *( osteo, reumas)*

**Yes No** w. Asthma, tuberculosis, or other lung disease *asma, tuberculosis, u otros problemas en los pulmones*

**Yes No** x. Stomach or intestinal disease  *Enfermedades estomacales o intesntinales*

**Yes No** y. Mental health condition – specify: *Problemas mentales - especifique*-:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Yes No** z. Physical or mental disabilities  *Incapacidades fisicas o mentales*

**Yes No** aa. Impairment of hearing, sight or speech.  *Problemas al escuchar, ver, o hablar*

**Yes No** bb. Do you have/or past been treated for cancer? *Tiene usted o ha sido tratatado de cancer?*

**Yes No** 2. Are you or could you be pregnant? *Esta usted o podria estar embarazada*

 Are you Nursing?  *Esta amamantando?*

**Yes No** 3. Do you have any disease, condition, or problem not listed here?

 Describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *Tiene usted alguna enfermedad, condicion o problema que no se menciono en el listado?*

*Describa:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Yes No** 4. Have you ever been hospitalized or had surgery? *Ha sido hospitalizado o tenido cirugias anteriormente?*

 Describe*:(Describa)*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Yes No** 5. Do you have any undiagnosed symptoms?  *Ha tenido algun sintoma que no ha sido diagnosticado?*

**Yes No** 6. Are you, or have you ever been addicted to a chemical substance?

 (examples: alcohol, prescription drugs, heroin, meth, cocaine, other)

  *Ha sido usted o es adicto a alguna substancia quimica?*

 *(ejemplos: alcohol, medicina recetada, heroina, meth, cocaina, otros)*

**Yes No** 7. Do you currently drink alcohol? *Toma usted bebidas alcoholicas*

**Yes No** Do you use recreational drugs? *Toma usted algun otro tipo de drogas?*

**Yes No** 8. Do you smoke or use smokeless tobacco? *Fuma o usa algo para prevenir tabaco?*

 What type of tobacco product(s) do you use? *Que tipo de tabaco usa?*

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 How interested are you in stopping your tobacco use? (Circle one)

  *Que tan interesado esta en dejar de fumar tabaco? ( circule el que aplique)*

Very interested somewhat interested Not at all interested

 *Muy interesado mas omenos interesado No interesado*

**Yes No** 11. Do you regularly take herbal medicines or dietary supplements?

  *Toma usted regularmente hierbas medicinales o suplementos dieteticos?*

 Echinacea Garlic(ajo) Ginger Kava Valerian Feverfew (poca fiebre) Gingko St John’s Wort Vitamin E ( vitamina E) Other (Otras):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Yes No** 12. Have you undergone current or past osteoporosis therapy?

  *Ha usted tenido receinte o anteriormente terapia para osteoporosis*

Examples are: *Ejemplos son:* Fosamax, Actonel, Boniva Pill form)

**Yes No** 13. Have you undergone current or past therapy to reduce high blood calcium (bisphosphonate

 Therapy)? ( Examples: Intravenous Aredia, Zometa)

 *Ha usted tenido terapia para reducir el alto calcio en la sangre (Terapia bisfosfonante)*

 *Ejemplos: Aredia Intravena, Zometa)*

**Dental History**

**Yes No** 14. Do you have regular dental check-ups? Date last exam:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

  *Hace sus chequeos dentales constantes? Fecha del ultimo examen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Yes No** 15. Have you had any trouble associated with previous dental treatment?:

 If so explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

  *Ha tenido problemas asociados con cualquier tratamiento dental anteriormente.*

 *Si es asi explique:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Yes No** 16. Have you noticed any lumps or sores in your mouth? *Ha notado alguna hinchazon o dolor en su boca?*

**Yes No** 17. Do your gums bleed when your brush your teeth? *Sus encias sangran cuando se cepilla sus dientes?*

 **Yes No** 18. Have you ever injured your face, jaws or teeth?  *Se ha fracturado su cara, quijada o dientes?*

 **Yes No** 19. Do you suffer from pain in the mouth, face, eyes, neck or throat?

 *Sufre usted de cualquier dolor en la boca, cara, ojos, cuello o garganta?*

**Yes No** 20. Do you want to save your teeth? *Le gustaría salvar sus dientes?*

**Yes No** 21. Has fear ever prevented you from seeking dental treatment?

  *Le ha detenido el miedo de buscar por un tratamiento dental?*

**Yes No** 22. Are you allergic to any metals or dental materials*? Es usted alérgico a cualquier material dental o metal?*

By signing below, you agree that the information given is accurate and that you will notify the clinic at subsequent appointments if there are any changes in your health.

*Al firmar abajo usted acuerda que la información dada es correcta y que notificara a la clínica en sus citas subsiguientes si hay algún cambio en su salud.*

**Patient Signature: *(Firma del Paciente*):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Signature of Provider\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
|   | **MIDTOWN HEALTH CENTER- DENTAL CLINIC** |   |   |
|   |  **List all Medications you are currently taking.**  |   |   |
|   | *Por favor mencione los medicamentos que esta tomando* |   |   |
| **Prescription Medication** | **Dose**  | **Frequency** |   |
| *Medicamentos* | *Dosis* | *Con que frecuencia toma su dosis* |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
| **Over the counter Products** | **Dose** | **Frequency** |   |
| *Productos sobre el mostrador* | *Dosis* | *Con que frecuencia toma su dosis* |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
| **Vitamins, Supplements** | **Dose** | **Frequency** |   |
| *Vitaminas, suplementos* | *Dosis* | *Con que frecuencia toma su dosis* |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
|  |  |  |  |
| **Signature** *( Firma)* **:** |  | **Date** *(Fecha)***:** |  |

*FOR OFFICE USE ONLY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

|  |  |  |  |
| --- | --- | --- | --- |
| Factor | Low | Moderate | High |
| Caries Activity | None | Within 24 months | Within 12 months |
| Demineralized areas | No white spots | 1 white spot | >1 white spot |
| Restorations or missing teeth due to caries | None | 1-2 Restorations within 36 months | 3 or more restorations OR extracted tooth within 36 months |
| Family History: Mother/Father/Siblings(age 14 and under) | None | Low Caries Rate | High Caries Rate |
| Presence of plaque, gingivitis | None | Moderate | Visible plaque on anterior teeth |
| Fluoride exposure | Optimal | Low to optimal | Low |
| Sugar Consumption | With meals only | 1-2 between meals | >3 between meals |
| Dental Home | Established | Irregular use | None |
| Special Conditions |  | Dental/orthodontic applianceDrug/alcohol abuseEating disorders | Enamel hypoplasiaSpecials needs patientImpaired salivary flow |
| **Overall assessment of Dental Caries Risk:** | **LOW** | **MODERATE** | **HIGH** |