

Date: _____

Patient: _____
 Last Name First Name MI

Home Address: _____
 Street Apt# City State Zip

Home Phone#: () _____ Work Phone#: () _____

Cell Phone#: () _____

Birth Date: ____/____/____ Sex: Male Female Transgender

Nearest Relative/Friend: _____/_____ Phone () _____
 (Not living with patient) Name Relationship

Has the patient ever received dental treatment at UCLA? No Yes

If yes, what year/under what name: _____ / _____
 Year Last Name First Name MI

Patient Ethnicity: White Black/African American Hispanic/Latino American Indian/Alaska Native
 Asian Native Hawaiian/Other Pacific Islander
 More than one race: _____

Additional Contact Information:

To ensure reliable contact between you, the patient, and UCLA Dental Clinics staff, students, and faculty, **YOU ARE REQUIRED TO PROVIDE A VALID E-MAIL ADDRESS** in the event we need to contact you regarding clinic policy changes and/or your pertinent medical information (i.e., test results, etc.). E-mail will be used **INTERNALLY ONLY** to provide updates and/or promotions as related to patient care and **WILL NOT BE DISTRIBUTED** outside the UCLA Dental Clinics.

E-mail: _____

I wish to opt-out of receiving e-newsletters from the UCLA Dental Clinics.

Medi-Cal & Dental Insurance Information: Medi-Cal#: _____

Dental Insurance Policy Holder: _____

Insurance Co.: _____ Group#: _____ Policy #: _____

Holder's Employer: _____
 Company Street City State Zip

HEALTH QUESTIONNAIRE

Patient Name: _____

Major dental problem or reason for coming to the UCLA Dental Center: _____

Please describe your general health: _____

What is your current weight? _____ What is your height? _____

Do you have or have you ever had any of the following?

	Yes	No
1. Injury to head, neck, jaw or teeth	<input type="checkbox"/>	<input type="checkbox"/>
2. Recurrent head, face, jaw or neck pain	<input type="checkbox"/>	<input type="checkbox"/>
3. Difficulty opening or closing jaw	<input type="checkbox"/>	<input type="checkbox"/>
4. Sore throat, hoarseness or difficulty swallowing.	<input type="checkbox"/>	<input type="checkbox"/>
5. Dry mouth, recurrent oral sores or irritation	<input type="checkbox"/>	<input type="checkbox"/>
6. Bleeding, infected gums or loose teeth	<input type="checkbox"/>	<input type="checkbox"/>
7. Decayed or broken teeth	<input type="checkbox"/>	<input type="checkbox"/>
8. Poor sleep, snoring or daytime sleepiness..	<input type="checkbox"/>	<input type="checkbox"/>
9. High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
10. Angina, chest pain or heart attack	<input type="checkbox"/>	<input type="checkbox"/>
11. Irregular or rapid heart beats.....	<input type="checkbox"/>	<input type="checkbox"/>
12. Pacemaker or defibrillator	<input type="checkbox"/>	<input type="checkbox"/>
13. Murmur, valvular disease or other heart defect..	<input type="checkbox"/>	<input type="checkbox"/>
14. Artificial heart valve	<input type="checkbox"/>	<input type="checkbox"/>
15. Cardiac or vascular surgery	<input type="checkbox"/>	<input type="checkbox"/>
16. Heart failure	<input type="checkbox"/>	<input type="checkbox"/>
17. Stroke	<input type="checkbox"/>	<input type="checkbox"/>
18. Emphysema or chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
19. Asthma	<input type="checkbox"/>	<input type="checkbox"/>
20. Lung infections (pneumonia, tuberculosis, other)	<input type="checkbox"/>	<input type="checkbox"/>
21. Anemia	<input type="checkbox"/>	<input type="checkbox"/>
22. Bleeding disorder or excessive clotting.....	<input type="checkbox"/>	<input type="checkbox"/>
23. HIV infection or other immune deficiency..	<input type="checkbox"/>	<input type="checkbox"/>
24. Autoimmune disease (RA, lupus, other)	<input type="checkbox"/>	<input type="checkbox"/>
25. Cancer	<input type="checkbox"/>	<input type="checkbox"/>
26. Radiation or chemotherapy for cancer	<input type="checkbox"/>	<input type="checkbox"/>
27. Organ transplant	<input type="checkbox"/>	<input type="checkbox"/>
28. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
29. Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
30. Adrenal or other endocrine disease.....	<input type="checkbox"/>	<input type="checkbox"/>
31. Currently pregnant or breast feeding	<input type="checkbox"/>	<input type="checkbox"/>
32. Reflux, peptic ulcer or colon disease	<input type="checkbox"/>	<input type="checkbox"/>
33. Hepatitis or other liver disease	<input type="checkbox"/>	<input type="checkbox"/>
34. Renal dialysis or other kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
35. STD (syphilis, gonorrhea, HSV, HPV or other) ..	<input type="checkbox"/>	<input type="checkbox"/>
36. Arthritis, persistent stiffness, painful joints	<input type="checkbox"/>	<input type="checkbox"/>
37. Artificial joint, implant	<input type="checkbox"/>	<input type="checkbox"/>
38. Treatment for Osteoporosis.....	<input type="checkbox"/>	<input type="checkbox"/>
39. Seizures	<input type="checkbox"/>	<input type="checkbox"/>
40. Numbness, tingling, or paralysis	<input type="checkbox"/>	<input type="checkbox"/>
41. Muscle weakness or multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
42. Movement disorders (Parkinson's, other) ..	<input type="checkbox"/>	<input type="checkbox"/>
43. Cognitive impairment (Alzheimer's, other).	<input type="checkbox"/>	<input type="checkbox"/>
44. Depression, anxiety disorder	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
45. Psychiatric conditions (schizophrenia, other)	<input type="checkbox"/>	<input type="checkbox"/>
46. Do you/ have you ever smoked/ used tobacco?.	<input type="checkbox"/>	<input type="checkbox"/>
47. Do you or have you ever abused alcohol? ..	<input type="checkbox"/>	<input type="checkbox"/>
48. Do you or have you ever used illicit substances?	<input type="checkbox"/>	<input type="checkbox"/>
49. Any other medical conditions not listed above	<input type="checkbox"/>	<input type="checkbox"/>
Please specify		

Allergies		Yes	No
50. Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	
51. Sulfa drugs.....	<input type="checkbox"/>	<input type="checkbox"/>	
52. Dental anesthetics.....	<input type="checkbox"/>	<input type="checkbox"/>	
53. Metals (rings or earrings)	<input type="checkbox"/>	<input type="checkbox"/>	
54. Latex.....	<input type="checkbox"/>	<input type="checkbox"/>	
55. Other	<input type="checkbox"/>	<input type="checkbox"/>	
Please specify			

Has anyone in your immediate family ever had?

56. Heart disease.....	<input type="checkbox"/>	<input type="checkbox"/>
57. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
58. Blood disorder	<input type="checkbox"/>	<input type="checkbox"/>
59. Cancer	<input type="checkbox"/>	<input type="checkbox"/>
60. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
61. Mental/emotional disorders	<input type="checkbox"/>	<input type="checkbox"/>

Please list all hospitalizations and emergency room visits (include dates and reasons):

1.	4.
2.	5.
3.	6.

Please list all prescriptions and non-prescription drugs you are currently taking (include doses and reasons):

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.