Elite Dentistry of Rhode Island

1351 South County Trail, Building 2 #205
East Greenwich, RI 02818-5080
Phone: 401-885-6460
Fax: 401-885-3933

Date:

Health History

Name of your physician?

Date of last dental/dental hygiene visit?

COVID-19 Screening

1. Have you traveled internationally in the last 14 days? ☐ Yes ☐ No

If yes, please provide your return date.

2. Have you been tested for COVID-19? ☐ Yes ☐ No

If yes, what type of test, date of test and the results of the test.

3. Have you been in close contact with another person who has been diagnosed for COVID-19? ☐ Yes ☐ No

4. Do you have a dry cough, flu-like symptoms, fever, headache, fatigue or shortness of breath? ☐ Yes ☐ No

5. Have you experienced recent loss of taste or smell? ☐ Yes ☐ No

6. Current body temperature °F:

Medical History

1. Are you under medical treatment now? ☐ Yes ☐ No

2. Have you ever been hospitalized for any surgical operation or serious illness? ☐ Yes ☐ No

3. Are you taking any medication(s) including non-prescription medicine? ☐ Yes ☐ No

If yes, what medication(s) are you taking?

4. Do you use tobacco? ☐ Yes ☐ No

5. Do you use alcohol? ☐ Yes ☐ No

6. Do you use cocaine or other drugs? ☐ Yes ☐ No

7. Are you wearing contact lenses? ☐ Yes ☐ No

8. Are you allergic to or have you had any reactions to the following?

Aspirin	☐ Yes ☐ No	Penicillin or other antibiotics	☐ Yes ☐ No
Barbiturates	☐ Yes ☐ No	Sedatives	☐ Yes ☐ No
Iodine	☐ Yes ☐ No	Sulfa drugs	☐ Yes ☐ No
Local anesthetics (e.g. Novocain)	☐ Yes ☐ No	Other	

9. Women only:

a. Are you pregnant or think you may be pregnant? ☐ Yes ☐ No

b. Are you nursing? ☐ Yes ☐ No

c. Are you taking birth control pills? ☐ Yes ☐ No

10. Do you have or have you had any of the following?

AIDS or HIV infection	☐ Yes ☐ No	High blood pressure	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Kidney diseases	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Joint replacement or implant	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Liver disease	☐ Yes ☐ No
Cardiac pacemaker	☐ Yes ☐ No	Low blood pressure	☐ Yes ☐ No
Chest pain	☐ Yes ☐ No	Radiation therapy	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Recent weight loss	☐ Yes ☐ No
Easily winded	☐ Yes ☐ No	Respiratory problems	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Rheumatic fever	☐ Yes ☐ No
Epilepsy/Convulsions	☐ Yes ☐ No	Sexually transmitted diseases	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	Stomach troubles/Ulcers	☐ Yes ☐ No
Hay fever/Allergies	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Heart attack	☐ Yes ☐ No	Swollen ankles	☐ Yes ☐ No
Heart diseases	☐ Yes ☐ No	Thyroid problem	☐ Yes ☐ No
Heart murmur	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Heart trouble	☐ Yes ☐ No	Other	
Hepatitis/Jaundice	☐ Yes ☐ No		

Dental History

1. Do your gums bleed while brushing or flossing? ☐ Yes ☐ No

2. Are your teeth sensitive to hot or cold liquid/food? ☐ Yes ☐ No

3. Are your teeth sensitive to sweet or sour liquid/food? ☐ Yes ☐ No

4. Do you feel pain in any of your teeth? ☐ Yes ☐ No

5. Do you have any sores or lumps in or near your mouth? ☐ Yes ☐ No

6. Have you had any head, neck or jaw injuries? ☐ Yes ☐ No

7. Have you ever experienced any of the following problems in your jaw?

a. Clicking? ☐ Yes ☐ No

b. Pain (joint, ear, side of face)? ☐ Yes ☐ No

c. Difficulty in opening or closing? ☐ Yes ☐ No

d. Difficulty chewing? ☐ Yes ☐ No

8. Do you have frequent headaches? ☐ Yes ☐ No

9. Do you clench or grind your teeth? ☐ Yes ☐ No

10. Do you bite your lips or cheeks frequently? ☐ Yes ☐ No

11. Have you had any difficult extractions in the past? ☐ Yes ☐ No

12. Have you had any orthodontic work? ☐ Yes ☐ No

13. Have you had any prolonged bleeding following extractions? ☐ Yes ☐ No

14. Have you ever had instruction on the correct method of brushing your teeth? ☐ Yes ☐ No

15. Have you ever had instructions on the care of your gums? ☐ Yes ☐ No

Current oral condition

1. How often do you brush your teeth?

2. How often do you floss your teeth?

3. What oral aids do you routinely use at home?

4. Do you want to keep your natural teeth? ☐ Yes ☐ No

5. Do you have complete dentures/partial dentures/fixed bridges/implants? ☐ Yes ☐ No

6. Do you clean your dental appliances? ☐ Yes ☐ No

7. Do you breathe through your mouth? ☐ Yes ☐ No

8. Do you favor one side of your mouth? ☐ Yes ☐ No

9. What do you want to change about your oral condition?

I have read my History and confirm that it adequately reflects past and present conditions.

Authorized signature of covered person (For minor, Parent or Guardian)

Date: _____