Willamette Dental Group

MEDICAL AND DENTAL HISTORY

PATIENT NAME (LAST, FIRST, MIDDLE INITIAL)	DATE OF BIRTH
PHYSICIAN NAME	PHYSICIAN PHONE

MEDICATION/SUPPLEMENT LIST *List all medications, herbal remedies and nicotine replacement therapy you are taking, including over-the-counter:*

MEDICAL HISTORY

		YES	NO
1.	Does your physician recommend that you receive antibiotic premedication for dental care?	◯	◯
2.	Are you now, or have you been in the last year, under the care of a physician?	◯	◯
3.	Have you had any serious illness, operation, or been hospitalized in the past five years?	◯	◯
4.	Do you have a history of Endocarditis (infected heart valve)?	◯	◯
5.	Have you had open heart surgery?	◯	◯
6.	Have you ever had an orthopedic total joint replacement (hip, knee, elbow, finger)?	◯	◯
7.	Have you ever had any radiation therapy or chemotherapy for a growth tumor or other condition?	◯	◯
8.	Are you taking prescription medications to manage pain daily or regularly?	◯	◯
	If Yes, are you on a 'Pain Contract'?	◯	◯
9.	Do you use or have you ever used tobacco?	◯	◯
	If Yes, ◯ Past Use ◯ Current Use		
10.	Do you drink alcoholic beverages?	◯	◯
11.	Do you use any substances for recreational purposes (marijuana, prescription or street drugs, other substances)?	◯	◯
12.	Have you taken, or are you scheduled to be taking oral bisphosphonates (Alendronate-Fosamax, Fosamax Plus D, Etidronate-Didronel, Ibandronate-Bonvia, Risedronate-Acetonel, Tiludronate-Skelid)?	◯	◯
13.	Have you taken/taking or are scheduled to begin taking intravenous biophosphonates (Clodronate-Benefos, Pamidronate-Aredia or Zolodronic Cid-Reclast, Zometa)?	◯	◯
IF APPLICABLE			
14.	Are you pregnant? / If Yes, How Many Weeks? / Due Date?	◯	◯
15.	Are you trying to become pregnant?	◯	◯
16.	Are you nursing?	◯	◯
17.	Are you taking birth control pills, fertility drugs or hormonal replacement?	◯	◯
MEDICAL CONDITIONS			
Do you have any of the following diseases, problems or symptoms?			
18.	Cardiovascular/heart problem (heart attack, heart murmur, high blood pressure, etc.)	◯	◯
19.	Respiratory/Lung problem (asthma, emphysema, COPD, tuberculosis, etc.)	◯	◯
20.	Diabetes/Thyroid problems	◯	◯
21.	Kidney/Urogenital Disorder (renal failure, dialysis, etc.)	◯	◯

Continued on next page

MEDICAL CONDITIONS CONTINUED		
22. Cancer or Tumors	◯	◯
23. Neurological/Nerve problem (stroke, seizures, MS, mental health disorders, etc.)	◯	◯
24. Blood/Hematologic disorder (anemia, leukemia, bleeding disorders, etc.)	◯	◯
25. Gastrointestinal (GI) Disorder (hepatitis, acid reflux, Crohn's, etc.)	◯	◯
26. Musculoskeletal/Connective tissue disorder (arthritis, osteoporosis, fibromyalgia, etc.)	◯	◯
27. Growth/Development problem (developmental delay, learning disability, behavioral problems, etc.)	◯	◯
28. Infectious disease (HIV/AIDS, MRSA, cold sores, STDs, etc.)	◯	◯
29 Head/Eye/Ear/Nose/Throat problem (glaucoma, cataract, hearing impairment, etc.)	◯	◯
30. Eating disorder (anorexia, bulimia, etc.)	◯	◯
31. Immunosuppression (compromised immune system)	◯	◯
32. Are all immunizations/vaccinations up to date?	◯	◯
33. Do you have any other problem, disease or condition not listed?	◯	◯
34. Are you allergic to or have you had a reaction to any substance or medication?	◯	◯

LIST ALL SUBSTANCES/MEDICATIONS YOU ARE ALLERGIC TO:	REACTION:

DENTAL HISTORY			
1. Chief Complaint?			
2. Date of your last dental visit:	3. What was done at that time?		
4. Date of your last dental x-rays:	5. Date of your last dental cleaning:		
6. Are you currently experiencing any dental pain or discomfort?		◯	◯
7. Are your teeth sensitive to cold, hot, sweets or pressure?		◯	◯
8. Do you have swelling in or around your mouth, face or neck?		◯	◯
9. Do you have loose teeth?		◯	◯
10. Do you have bad breath, metallic taste or unpleasant taste?		◯	◯
11. Do you have any clicking, popping or discomfort in your jaw?		◯	◯
12. Do you clench, brux or grind your teeth?		◯	◯
13. Do you have sores, ulcers or tumors in your mouth?		◯	◯
14. Have you had any periodontal treatments? (deep cleaning/gum surgery)		◯	◯
15. Have you ever had orthodontic treatment? (braces, retainers)		◯	◯
16. Have you ever had local anesthetic (numbing) for dental purposes?		◯	◯
If yes, have you experienced any problems?		◯	◯
17. Have you had problems associated with previous dental treatment?		◯	◯
18. How often do you brush your teeth?	◯ Never ◯ Sometimes ◯ Once a day ◯ Twice a day ◯ More than twice a day		
19. How often do you floss your teeth?	◯ Never ◯ Sometimes ◯ Once a day ◯ Twice a day ◯ More than twice a day		
20. Do your gums bleed when you brush or floss?	◯ Never ◯ Sometimes ◯ Always		
21. Do you have any obstacles to cleaning or caring for your teeth?		◯	◯
22. Rate your fear of dental treatment on a scale of 0 (no fear) to 10 (extreme fear):			
0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯			
23. How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?			
◯ Never ◯ Rarely ◯ Sometimes ◯ Often ◯ Always			
24. Do you have any previous or present activities or behaviors that may place you at risk for facial injury?		◯	◯