Willamette Dental

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				YES	NO
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		YES	NO
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.)	◯	◯

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MEDICAL CONDITIONS CONTINUED		YES	NO
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			YES	NO
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?		○	○