Willamette Dental

Patient Summary Form

PATIENT INFORMATION		
Last name:	First name:	Middle name:
Mailing address:	City, State, Zip:	
Mobile phone number:	Email address:	
Pronouns: ☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs ☐ Ze/Zir/Zirs ☐ Ze/Hir/Hirs	Gender: ☐ Male ☐ Female ☐ Transgender ☐ I'd Rather Not Say/Unspecified ☐ Other	
Race/ethnicity identification* (please check all that apply): ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ Hispanic or Latino/a ☐ American Indian or Alaska Native ☐ White/Caucasian ☐ Other (not listed) ☐ Decline to answer	Language preference: ☐ English ☐ Spanish ☐ Russian ☐ Chinese ☐ Other	
Date of birth:	Preferred contact method** (please check one): ☐ Email ☐ Text ☐ Phone	

**This information helps us ensure that we are providing the highest quality care for our patients. Studies have shown that racial/ethnic backgrounds may impact our patients' oral health risk for certain diseases. Recording patient data regarding race and ethnicity will allow Willamette Dental to better understand and meet our patients' oral health needs. This information is not given away, sold, or used for anything other than Willamette Dental business.*

***You'll receive messages with important information from your dental team about your appointments and treatment through your preferred contact method.*

EMERGENCY CONTACT		
Name:	Relationship:	Phone:
PREFERRED PHARMACY & PHYSICIAN		
Pharmacy Name:	Pharmacy Phone:	
Pharmacy Address:		
Physician Name:	Physician Phone:	
MEDICATIONS/SUPPLEMENT LIST *List all medications, herbal remedies and nicotine replacement therapy you are taking, including over-the-counter.*		

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DENTAL HISTORY

1. Chief concern:

2. When was your last routine dental checkup/cleaning?

3. When were your last dental x-rays?

4. Have you had any of the following dental procedures?

☐ Dental implants	☐ Periodontal (gum) surgery
☐ Endodontics (root canals)	☐ Removable appliances (dentures or partials)
☐ Extractions (teeth pulled)	☐ Scaling and root planing
☐ Orthodontia (braces)	☐ Other, please describe:

5. Have you had any problems with local anesthetic, nitrous, sedatives, or problems getting numb in the past?
☐ Yes ☐ No

☐ Local anesthetic reaction	☐ Problems getting numb
☐ Nitrous reaction	☐ Other:
☐ Sedation reaction	

6. Are you currently experiencing or have you experienced any dental pain, discomfort, swelling, or bleeding?
☐ Yes ☐ No

☐ Pain	☐ Swelling
☐ Sensitivity	☐ Face
☐ Cold	☐ Mouth
☐ Hot	☐ Neck
☐ Sweets	☐ Bleeding
☐ Pressure	

7. Do you have any additional concerns with your teeth or mouth? ☐ Yes ☐ No

☐ Bad breath	☐ Prone to aphthous ulcers
☐ Clench or brux (grind) your teeth	☐ Prone to cold sores
☐ Clicking jaw	☐ Sores
☐ Discomfort in the jaw	☐ Tumors
☐ Loose teeth	☐ Ulcers
☐ Metallic taste	☐ Unpleasant taste
☐ Popping jaw	☐ Other:

8. 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

9. Do you have any special requests regarding your care that you would like your dental team to be made aware of?

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MEDICAL HISTORY

1. Are you now, or have you been in the last year, under the care of a physician? ☐ Yes ☐ No
If yes, what is/are the conditions being treated?

2. Have you had any serious illness, operation, or been hospitalized in the past 5 years? ☐ Yes ☐ No
If yes, please describe:

3. Do you have a history of surgical procedures? ☐ Yes ☐ No
If yes, please select the surgical procedures you have undergone below.

☐ Appendectomy	☐ Broken bone repair	☐ Eye	☐ Joint replacement
☐ Back	☐ Cardiac	☐ Gall bladder removal	☐ Organ transplant
☐ Brain	☐ C-section	☐ Hysterectomy	☐ Tonsils/Adenoids

☐ Other, details:

4. Are you taking prescription medications to manage pain daily or regularly? ☐ Yes ☐ No

If yes, are you on a 'Pain Contract'? ☐ Yes ☐ No

If yes, please describe:

5. Do you use or have you ever used tobacco or nicotine products? ☐ Yes ☐ No If yes, ☐ Past Use ☐ Current Use

If yes, please select the types of tobacco or nicotine products you use or have used:
☐ Bidis ☐ Chewing tobacco ☐ Cigars ☐ E-cig/Vaping ☐ Hookah ☐ Nicotine gum ☐ Nicotine patches
☐ Nicotine pouches ☐ Smoking ☐ Snuff ☐ Other, details:

6. Do you drink 3 or more alcoholic beverages per day on a regular basis? ☐ Yes ☐ No

Are you alcohol dependent? ☐ Yes ☐ No	Have you received treatment? ☐ Yes ☐ No

7. Do you use any substances for recreational purposes (marijuana, prescription or street drugs, other substances)?
☐ Yes ☐ No If yes, ☐ Past Use ☐ Current Use If yes, please select the substances you use or have used below.

☐ Cocaine	☐ Heroin	☐ Methamphetamine	☐ Other, please specify:
☐ Ecstasy	☐ Marijuana	☐ Oxycontin	Are you drug dependent? ☐ Yes ☐ No

8. Have you taken, or are you scheduled to be taking: Oral or IV bisphosphonates? ☐ Yes ☐ No
If yes, please select the medications below.

☐ Alendronate (Fosamax)	☐ Clodronate (Bonefos)	☐ Etidronate (Didronel)	☐ Fosamax Plus D
☐ Ibandronate (Boniva)	☐ Pamidronate (Aredia)	☐ Risedronate (Actonel)	☐ Tiludronate (Skelid)

☐ Zolodronic Acid (Reclast, Zometa)

IF APPLICABLE

9. Are you, or could you be, pregnant? ☐ Yes ☐ No If yes, how many weeks? Due date?

10. Are you nursing? ☐ Yes ☐ No	**11. Are you taking birth control pills, fertility drugs, or hormonal replacement?** ☐ Yes ☐ No

MEDICAL CONDITIONS

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES, PROBLEMS, OR SYMPTOMS?

12. Cardiovascular/Heart problem ☐ Yes ☐ No

☐ A-fib	☐ Congenital heart defect	☐ Implantable defibrillator	☐ Rheumatic fever/Rheumatic heart disease
☐ Angina (chest pain)	☐ Congestive heart failure	☐ Infective endocarditis	☐ Shortness of breath
☐ Arteriosclerosis	☐ Coronary heart disease	☐ Mitral valve prolapsed	☐ Sleep on two or more pillows
☐ Artificial heart valve(s)	☐ Damaged heart valve	☐ Open heart surgery	☐ Swelling of the ankles
☐ Arrhythmia (irregular heart beat)	☐ Heart attack	☐ Pacemaker	☐ Other:
☐ Blood pressure - High	☐ Heart murmur	☐ Palpitations	
☐ Blood pressure - Low	☐ High cholesterol	☐ Postural orthostatic tachycardia syndrome (POTS)	

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MEDICAL CONDITIONS CONTINUED

13. Respiratory/Lung problem ☐ Yes ☐ No

☐ Asthma	☐ Sarcoidosis
☐ Bronchitis	☐ Sleep apnea
☐ Emphysema/COPD	☐ Snoring
☐ Persistent cough	☐ Tuberculosis
☐ Pneumonia	☐ Other:

14. Diabetes disorder ☐ Yes ☐ No

☐ A1C Level:	☐ Pre-diabetic
☐ Blood sugar level:	☐ Type 1
☐ Gestational	☐ Type 2

15. Endocrine disorder ☐ Yes ☐ No

☐ Addison's	☐ Hypothyroidism
☐ Adrenal gland disorder	☐ Hyperthyroidism
☐ PCOS	☐ Other:
☐ Thyroid problems	

16. Kidney/Urogenital disorder ☐ Yes ☐ No

☐ Dialysis	☐ Prostate problems
☐ Kidney stones	☐ Renal failure/insufficiency
☐ Frequent urination	☐ Other:

17. Cancer/Tumors/Chemotherapy/Radiation Treatment ☐ Yes ☐ No

☐ Cancer/tumors If yes, ☐ Malignant ☐ Benign

☐ Bladder	☐ Leukemia: Acute Lymphocytic	☐ Lymphoma: Hodgkin's	☐ Skin: Melanoma
☐ Breast	☐ Leukemia: Chronic Lymphocytic	☐ Lymphoma: Non-Hodgkin's	☐ Skin: Non-melanoma
☐ Colorectal	☐ Leukemia: Acute Myelogenous	☐ Multiple myeloma	☐ Thyroid
☐ Endometrial	☐ Leukemia: Chronic Myelogenous	☐ Pancreatic	☐ Other cancer/tumors:
☐ Kidney	☐ Lung	☐ Prostate	

☐ Chemotherapy	☐ Radiation treatment to Head/Neck region	☐ Other Radiation treatment

18. Neurologic/Nerve problem ☐ Yes ☐ No

☐ Dementia/Alzheimer's (memory loss)	☐ Headache	☐ Seizures/Epilepsy	☐ Vertigo
☐ Fainting or dizzy spells	☐ Migraine	☐ Stroke	☐ Weakness
☐ Feeling of tingling or numbness	☐ Neuropathies	☐ TIA (transient ischemic attack)	☐ Other
☐ Fibromyalgia	☐ Parkinson's disease	☐ Trigeminal neuralgia	

19. Mental health disorder ☐ Yes ☐ No

☐ ADD/ADHD (Attention Deficit (Hyperactivity) Disorder)
☐ Anxiety
☐ Bipolar/manic depression
☐ Depression
☐ Obsessive/compulsive disorder
☐ Post Traumatic Stress disorder
☐ Schizophrenia
☐ Other:

20. Blood/Hematologic disorder/Transfusions ☐ Yes ☐ No

☐ Anemia	☐ Bruise easily
☐ Bleeding disorders	☐ Deep Vein Thrombosis
☐ Drug induced	☐ Sickle Cell Anemia
☐ Hemophilia	☐ Sickle Cell Trait
☐ Idiopathic Thrombocytopenic Purpura	☐ Thalassemia
☐ Von Willebrand's	☐ Transfusions - Date:
☐ Other:	

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MEDICAL CONDITIONS CONTINUED

Do you have or have you had any of the following diseases, problems, or symptoms?

21. Gastrointestinal (GI) disorder ☐ Yes ☐ No		**22. Hepatitis/Jaundice/Liver disease** ☐ Yes ☐ No	
☐ Acid Reflux (GERD)	☐ Irritable Bowel Syndrome (IBS)	☐ Cirrhosis/Chronic Liver Disease	☐ Hepatitis: Other:
☐ Crohn's disease	☐ Ulcers	☐ Hepatitis: Type A	☐ Jaundice (skin/eyes turn yellow)
☐ Gall Stones	☐ Other:	☐ Hepatitis: Type B	
☐ Heartburn		☐ Hepatitis: Type C	

23. Musculoskeletal/Connective tissue disorder ☐ Yes ☐ No		**24. Autoimmune disorder** ☐ Yes ☐ No	
☐ Arthritis: Rheumatoid	☐ Neck/back problems	☐ Drug or radiation induced immunosuppression	
☐ Arthritis: Osteoarthritis	☐ Osteoporosis	☐ Lupus	☐ Sjogren's disorder
☐ Arthritis: Other:	☐ Spinal fusions	☐ Multiple sclerosis	☐ Other:
☐ Gout	☐ Temporomandibular Joint Disorder (TMD)	☐ Psoriasis	
☐ Herniated discs	☐ Other:	☐ Scleroderma	

25. Behavior/Growth/Development problem ☐ Yes ☐ No		**26. Infectious disease** ☐ Yes ☐ No	
☐ Autism	☐ Neuroatypical	☐ AIDS	☐ STI (Sexually Transmitted Infection)
☐ Behavioral problems	☐ Non-verbal	☐ HIV	☐ If yes, please describe:
☐ Developmental delay	☐ Physical growth problem	☐ Methicillin-resistant Staph aureus (MRSA)	
☐ Excessive nervousness	☐ Premature Birth/ Pregnancy complications	☐ Mononucleosis	
☐ Genetic disorder	☐ Tourette Syndrome	☐ Other:	
☐ Intellectual/Learning disability	☐ Other:		

27. Head/Eye/Ear/Nose/Throat problem ☐ Yes ☐ No		**28. Eating disorder** ☐ Yes ☐ No
☐ Cataract	☐ Tonsil Stones	☐ Anorexia
☐ Glaucoma	☐ Vision problems	☐ Bulimia
☐ Hearing impairment	☐ Wear contact lenses	☐ Other:
☐ Tonsilitis	☐ Other:	

29. Do you have any other problem, disease, or condition not listed? ☐ Yes ☐ No

If yes, please specify:

ALLERGIES

30. Do you have any allergies? ☐ Yes ☐ No If yes, please select the applicable options below.

☐ Animals	☐ Local anesthetics (or their preservatives)	☐ Latex (rubber)	☐ Other:
☐ Aspirin	☐ Food	☐ Metals/Jewelry (nickel/ chrome)	
☐ Barbiturates (sedatives or sleeping pills)	☐ Hay fever/seasonal allergies	☐ Penicillin	
☐ Codeine or other narcotics	☐ Iodine	☐ Sulfa drugs	