Willamette Dental

Patient Summary Form

PATIENT INFORMATION

Last name:	First name:	Middle name:
Mailing address:	City, State, Zip:	
Mobile phone number:	Email address:	
Preferred name: 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 all that apply): ☐ 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 ☐ Endodontics (root canals) ☐ Extractions (teeth pulled) ☐ Orthodontia (braces)
☐ Periodontal (gum) surgery ☐ Removable appliances (dentures or partials) ☐ Scaling and root planing
☐ Other, please describe: _____

5. Have you had any problems with local anesthetic, nitrous, sedatives, or problems getting numb in the past?
☐ Yes ☐ No If yes, select all that apply below.

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

6. Are you currently experiencing or have you experienced any dental pain, discomfort, swelling, or bleeding?
☐ Yes ☐ No If yes, select all that apply below.

☐ Pain ☐ Sensitivity to cold ☐ Sensitivity to hot ☐ Sensitivity to sweets ☐ Sensitivity to pressure
☐ Swelling of the face ☐ Swelling of the mouth ☐ Swelling of the neck ☐ Bleeding

7. Do you have any additional concerns with your teeth or mouth? ☐ Yes ☐ No
If yes, select all that apply below.

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

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 ☐ Back ☐ Brain ☐ Broken bone repair ☐ Cardiac ☐ C-section ☐ Eye
☐ Gall bladder removal ☐ Hysterectomy ☐ Joint replacement ☐ Organ transplant ☐ Tonsils/Adenoids
☐ Other, details: _____

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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 ☐ Ecstasy ☐ Heroin ☐ Marijuana ☐ Methamphetamine ☐ Oxycontin
☐ Other, please specify: _____ 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** **If yes, please select all that apply below.**

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

13. Respiratory/Lung problem ☐ **Yes** ☐ **No** **If yes, please select all that apply below.**

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

14. Diabetes disorder ☐ **Yes** ☐ **No** **If yes, please select all that apply below.**

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

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MEDICAL CONDITIONS CONTINUED

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

15. Endocrine disorder ☐ **Yes** ☐ **No** **If yes, please select all that apply below.**

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

16. Kidney/Urogenital disorder ☐ **Yes** ☐ **No** **If yes, please select all that apply below.**

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

17. Cancer/Tumors/Chemotherapy/Radiation Treatment ☐ **Yes** ☐ **No** **If yes, please select all that apply below.**

☐ Cancer/tumors If yes, ☐ Malignant ☐ Benign

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

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

18. Neurologic/Nerve problem ☐ **Yes** ☐ **No** **If yes, please select all that apply below.**

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

19. Mental health disorder ☐ **Yes** ☐ **No** **If yes, please select all that apply below.**

☐ 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** **If yes, please select all that apply below.**

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

21. Gastrointestinal (GI) disorder ☐ **Yes** ☐ **No** **If yes, please select all that apply below.**

☐ Acid Reflux (GERD) ☐ Crohn's disease ☐ Gall Stones ☐ Heartburn ☐ Irritable Bowel Syndronme (IBS) ☐ Ulcers
☐ Other: _____

22. Hepatitis/Jaundice/Liver disease ☐ **Yes** ☐ **No** **If yes, please select all that apply below.**

☐ Cirrhosis/Chronic Liver Disease ☐ Hepatitis: Type A ☐ Hepatitis: Type B ☐ Hepatitis: Type C
☐ Hepatitis: Other: _____ ☐ Jaundice (skin/eyes turn yellow)

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MEDICAL CONDITIONS CONTINUED

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

23. Musculoskeletal/Connective tissue disorder ☐ **Yes** ☐ **No** **If yes, please select all that apply below.**

☐ Arthritis: Rheumatoid ☐ Arthritis: Osteoarthritis ☐ Arthritis: Other: _____ ☐ Gout
☐ Herniated discs ☐ Neck/back problems ☐ Osteoporosis ☐ Spinal fusions
☐ Temporomandibular Joint Disorder (TMD) ☐ Other: _____

24. Autoimmune disorder ☐ **Yes** ☐ **No** **If yes, please select all that apply below.**

☐ Drug or radiation induced immunosuppression ☐ Lupus ☐ Multiple sclerosis ☐ Psoriasis ☐ Scleroderma
☐ Sjogren's disorder ☐ Other: _____

25. Behavior/Growth/Development problem ☐ **Yes** ☐ **No** **If yes, please select all that apply below.**

☐ Autism ☐ Behavioral problems ☐ Developmental delay ☐ Excessive nervousness ☐ Genetic disorder
☐ Intellectual/Learning disability ☐ Neuroatypical ☐ Non-verbal ☐ Premature Birth/Pregnancy complications
☐ Physical growth problem ☐ Tourette Syndrome ☐ Other: _____

26. Infectious disease ☐ **Yes** ☐ **No** **If yes, please select all that apply below.**

☐ AIDS ☐ HIV ☐ Methicillin-resistant Staph aureus (MRSA) ☐ Mononucleosis
☐ STI (Sexually Transmitted Infection): If yes, please describe: _____ ☐ Other: _____

27. Head/Eye/Ear/Nose/Throat problem ☐ **Yes** ☐ **No** **If yes, please select all that apply below.**

☐ Cataract ☐ Glaucoma ☐ Hearing impairment ☐ Tonsilitis ☐ Tonsil Stones ☐ Vision problems
☐ Wear contact lenses ☐ Other: _____

28. Eating disorder ☐ **Yes** ☐ **No** **If yes, please select all that apply below.**

☐ Anorexia ☐ Bulimia ☐ 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 all that apply below.**

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