bothell family dental care

Medical and Dental History Form

Patient Name _____ **Date** _____
Last *First* *Middle* **Date of Birth** _____

Do you have any of the following diseases or problems: (Check next to the box that fits your description)
☐Active Tuberculosis
☐Persistent cough greater than a 3 week duration
☐Cough that produces blood
☐Been exposed to anyone with tuberculosis
If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information

What is the reason for your dental visit today?
☐Routine care (cleaning and exam) ☐Emergency (tooth pain) ☐Consultation ☐Other, explain: _____
How do you feel about your smile? _____
_____

☐*Yes* ☐*No* Do your gums bleed when you brush or floss?
☐*Yes* ☐*No* Are your teeth sensitive to cold, hot, sweets, or pressure?
☐*Yes* ☐*No* Is your mouth dry?
☐*Yes* ☐*No* Have you had any periodontal (gum) treatments?
☐*Yes* ☐*No* Have you ever had orthodontic (braces) treatment?
☐*Yes* ☐*No* Have you had any problems associated with previous dental treatment?
☐*Yes* ☐*No* Is your home water supply fluoridated?
☐*Yes* ☐*No* Do you drink bottled or filtered water?
If yes, how often? *Circle one*: DAILY / WEEKLY / OCCASIONALLY
☐*Yes* ☐*No* Are you currently experiencing dental pain or discomfort?
☐*Yes* ☐*No* Do you have earaches or neck pains?

☐*Yes* ☐*No* Do you have any clicking, popping or discomfort in the jaw?
☐*Yes* ☐*No* Do you brux or grind your teeth?
☐*Yes* ☐*No* Do you have sores or ulcers in your mouth?
☐*Yes* ☐*No* Do you wear dentures or partials?
☐*Yes* ☐*No* Do you participate in active recreational activities?
☐*Yes* ☐*No* Have you ever had a serious injury to your head or mouth?
Date of your last dental exam: _____
What was done at that time? _____
_____
Date of last dental x-rays: _____

Medical Information

☐*Yes* ☐*No* Are you now under the care of a physician?

Physician Information

Name _____
Address _____
Phone number _____

☐*Yes* ☐*No* ☐*Don't know* Are you in good health?
☐*Yes* ☐*No* ☐*Don't know* Has there been any change in your general health within the past year?
If yes, what condition is being treated? _____
_____
Date of last physical exam: _____

☐*Yes* ☐*No* Have you had a serious illness, operation or been hospitalized in the past 5 years?
If yes, what was the illness or problem? _____
_____
☐*Yes* ☐*No* Are you taking or have you recently taken any prescription or over the counter medicine(s)?
If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:
_____
_____
_____
_____
_____

☐*Yes* ☐*No* Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement
Date: _____
If yes, have you had any complications? _____
☐*Yes* ☐*No* Are you taking or scheduled to begin taking an **antiresorptive agent** (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease?
☐*Yes* ☐*No* Since 2001, were you treated or are you presently scheduled to begin treatment with an **antiresorptive agent** (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?

☐*Yes* ☐*No* Do you use controlled substances (drugs?
☐*Yes* ☐*No* Do you use tobacco (smoking, snuff, chew, bidis)?
If so, how interested are you in stopping?
Circle one: VERY / SOMEWHAT / NOT INTERESTED
☐*Yes* ☐*No* Do you drink alcoholic beverages

WOMEN ONLY Are you:
☐*Yes* ☐*No* ☐*Don't know* Pregnant
Number of weeks: _____
☐*Yes* ☐*No* Taking birth control pills or hormonal replacement?
☐*Yes* ☐*No* Nursing?

Allergies

Allergies. Are you allergic to or have you had a reaction to (To all yes responses, specify type of reaction):
☐Local anesthetics _____
☐Aspirin _____
☐Penicillin or other antibiotics _____
☐Barbiturates, sedatives, or sleeping pills _____
☐Sulfa drugs_____
☐Codeine or other narcotics _____
☐Metals _____
☐Latex (rubber) _____
☐Iodine _____
☐Hay fever/seasonal _____
☐Animals _____
☐Food _____
☐Other: _____

Heart Conditions

☐Artificial (prosthetic) heart valve
☐Previous infective endocarditis
☐Damaged valves in transplanted heart
☐Congenital heart disease (CHD)
☐Unrepaired, cyanotic CHD
☐Repaired (completely) in last 6 months
☐Repaired CHD with residual defects

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

(*Check next to the box that fits your description*)

☐Cardiovascular disease
☐Angina
☐Arteriosclerosis
☐Congestive heart failure
☐Damaged heart valves
☐Heart attack
☐Heart murmur
☐Low blood pressure
☐High blood pressure
☐Other congenital heart defects
☐Mitral valve prolapse
☐Pacemaker
☐Rheumatic fever
☐Rheumatic heart disease
☐Abnormal bleeding
☐Anemia
☐Blood transfusion
If yes, date:_____
☐Hemophilia
☐AIDS or HIV infection
☐Arthritis
☐Autoimmune disease
☐Rheumatoid arthritis
☐Systemic lupus erythematosus
☐Asthma
☐Bronchitis
☐Emphysema
☐Sinus trouble
☐Tuberculosis
☐Cancer/Chemotherapy/Radiation treatment
☐Chest pain upon exertion
☐Chronic pain
☐Diabetes Type I or II
☐Eating disorder
☐Malnutrition
☐Gastrointestinal disease
☐G.E. Reflux/persistent heartburn
☐Ulcers
☐Thyroid problems
☐Stroke
☐Glaucoma
☐Hepatitis, jaundice or liver disease
☐Epilepsy
☐Fainting spells or seizures
☐Neurological disorders
If yes, specify:_____
☐Sleep disorder
☐Do you snore
☐Mental health disorders
If yes, specify:_____
☐Recurrent Infections
Type of infection: _____
☐Kidney problems
☐Night sweats
☐Osteoporosis
☐Persistent swollen glands
☐in neck
☐Severe headaches/
☐migraines
☐Severe or rapid weight loss
☐Sexually transmitted disease
☐Excessive urination

☐*Yes* ☐*No* ☐*Don't know* Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?
Name and phone number of physician or dentist making recommendation:
_____
_____

☐*Yes* ☐*No* ☐*Don't know* Do you have any disease, condition, or problem not listed above that you think I should know about?
Please explain:
_____
_____

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

_____ Date _____
Patient signature/legally authorized representative.

_____ Relationship _____
Printed name if signed on behalf of the patient

_____ Date _____
Dentist signature