Washington Family Dental

Medical History Form

Patient Name:________________________________ Date of Birth:_________________

Although dental personnel primarily treat the area in and around the mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Please check the box if you have, or have been diagnosed with, any of the following conditions

Heart Health

☐ Congenital heart disease (CHD) ☐ Unrepaired, cyanotic CHD ☐ Repaired (completely) in the last 6 months ☐ Repaired CHD with residual defects	☐ Artificial (prosthetic) heart valve ☐ Congestive heart failure ☐ Rheumatic heart disease ☐ Heart attack ☐ Heart murmur/ rhythm disorder	☐ Previous infective endocarditis ☐ Damaged heart valves ☐ Stroke ☐ Arteriosclerosis ☐ Coronary artery disease ☐ Pacemaker/ Implanted defibrillator

Breathing (Respiratory) Health

☐ Asthma ☐ COPD ☐ Tuberculosis	☐ Bronchitis ☐ Residual lung complications from COVID	☐ Emphysema ☐ Sinus trouble

Blood (Circulatory) Health

☐ Anemia ☐ Blood transfusion Date of transfusion:_____________	☐ Low blood pressure ☐ High blood pressure ☐ Hemophilia

Brain (Neurological)/ Mental Health

☐ Anxiety ☐ Neurological disorders ☐ Mental Health Disorders	☐ Depression ☐ Post-traumatic stress disorder	☐ Epilepsy ☐ Traumatic brain injury or concussion

Autoimmune Disease	**Eye Health**
☐ Aids or HIV infection ☐ Lupus	☐ Glaucoma

Digestive Health

☐ Gastrointestinal Disease	☐ G.E. Reflux/ Persistent heartburn (GERD)	☐ Stomach Ulcers

Other

☐ Arthritis ☐ Hepatitis, jaundice, or liver disease ☐ Osteoporosis	☐ Chronic Pain ☐ Immune deficiency ☐ Rheumatoid ☐ Thyroid problems	☐ Diabetes (type 1 or type 2) ☐ Kidney problems ☐ Sexually transmitted infection	☐ Eating disorder ☐ Malnutrition ☐ Taking immunosuppressants

Have you been, or had you been in the past, diagnosed with cancer?_____________
If yes, please explain:

In the past 30 days, have you:

☐ Had pain of tightness in the chest? ☐ Found it hard to catch your breath? ☐ Experienced vomiting, diarrhea, chills?	☐ Coughed up blood or had a cough that lasted more than 3 weeks? ☐ Had a high fever (greater than 101.5°)? ☐ Had a migraine or severe headaches?	☐ Been exposed to anyone with tuberculosis? ☐ Noticed a change in your vision? ☐ Had a rapid or irregular heartbeat? ☐ Fainted for no reason?

Are you allergic to any of the following?

☐ Aspirin ☐ Metals ☐ Sulfa Drugs	☐ Penicillin ☐ Latex ☐ Codeine or other narcotics	☐ Dental Anesthetics ☐ Local Anesthetics ☐ Acrylic

(Sulfa drugs: such as sulfamethoxazole-trimethoprim (Septra, Bactrim), erythromycin-sulfisoxazole, sulfasala-zine (Azulfidine), erythromycin-sulfisoxazole (Eryzole, Pediazole) glyburide (Diabeta, Glynase PresTabs), dapsone, sumatriptan (Imitrex), celecoxib (Celebrex), hydrochlorothiazide (Microzide) and furosemide (Lasix))

Please mark yes or no to the following questions:

Are you taking any blood thinners (such as Coumadin, Warfarin, rivaroxaban (Xarelto®), dabigatran (Pradaxa®), clopidogrel (Plavix®), heparin or aspirin? If yes, what medications? ____

Are you taking any medication to treat osteoporosis or Paget's disease? If yes, what medications?

____

Some commonly prescribed medications are: alendronate (Fosamax®), risedronate (Actonel®), ibandronate (Boniva®), zoledronate (Reclast®), and denosumab (Prolia®).

Are you taking, or scheduled to take, an IV medication to treat bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? If yes, what medication are you taking?

____

Some commonly-prescribed drugs include denosumab (Xgeva®), pamidronate (Aredia®), or zoledronate (Zometa®)

Are you taking hormonal replacements? ____

Do you use any form of tobacco or nicotine products (cigarettes, cigars, snuff, chew, bidis)?___________________
Do you use vaping products? ______________________
How many alcoholic beverages do you have per week? ______________________________
Do you use controlled substances (drugs), including marijuana, for either medicinal or recreational reasons?____
IF yes, what substance(s) and how often is your use?____
Was the substance prescribed by a doctor?_____ For what reason? ____________________________________

Please list any other prescriptions and/or over the counter medicine(s), vitamins, herbs and/or supplements

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Medical/ Surgical History

Are you currently being seen or treated by a physician? ________
Physicians Name: ___________________ Phone Number: ________________________

Has a physician or previous dentist recommended that you take antibiotics before haivng dental work done?
____

Have you had a serious illness, operation, or been hospitalized in the past 5 years?_________________________

Have you had any type (total or partial) of joint replacement surgery (hip, knee, shoulder, elbow, finger, etc?)
____

Have you had heart valve replacement or heart surgery? ____

Have you had an organ, bone marrow, or stem cell transplant? ____

Women: Are you…

☐ pregnant/ trying to get pregnant?	☐ Nursing?

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian:____
Date: __________________________