SELECT CARE DENTAL Redmond

PATIENT MEDICAL HISTORY

Physician_____ Office Phone_____ Date of Last Exam_____

	Yes	No
1. Are you currently under medical treatment now or being tested for a medical condition? If yes, please explain _____	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain_____	☐	☐
3. Please list any medications or supplements that you are currently taking_____	☐	☐
4. Do you use tobacco? Frequency_____	☐	☐

5. **Dental History:**

Name of Previous Dentist_____

Location of Previous Dentist_____

Date of Last Exam_____

– Have you ever been pre-medicated with antibiotics prior to a dental appointment? If so, why_____	☐	☐
Do you feel pain in any of your teeth?	☐	☐
Do you have any sores or lumps in or near your mouth?	☐	☐
Have you had any head, neck or jaw injuries?	☐	☐
Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain Joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐
- Do you clench your teeth?	☐	☐
- Have you ever had any prolonged bleeding following dental extractions?	☐	☐
- Do you like your smile?	☐	☐

	Yes	No
6. Are you allergic to or had any reactions to the following?	☐	☐
- Local Anesthetics (e.g. Novocain)		
- Penicillin	☐	☐
- Other Antibiotics_____	☐	☐
- Codeine	☐	☐
- Sulpha	☐	☐
- Sedatives	☐	☐
- Aspirin	☐	☐
- Any Metals, If yes what kind_____		
- Latex Rubber	☐	☐
- Other Allergies_____	☐	☐
- WOMEN ONLY		
- Are you pregnant or think you may be pregnant?	☐	☐
- Are you nursing?	☐	☐
- Are you taking oral contraceptives?	☐	☐

7. Do you have or have you had any of the following?

	Year Diagnosed		
Angina	_____	☐	☐
Arthritis		☐	☐
Asthma	_____	☐	☐
Bisphosphonate Therapy	_____	☐	☐
Cancer.....Type	_____	☐	☐
Cardiac Pacemaker.		☐	☐
Celiac Disease	_____	☐	☐
Diabetes.....Type ____	_____	☐	☐
Emphysema	_____	☐	☐
Epilepsy/Convulsions	_____	☐	☐
Glaucoma		☐	☐
Heart Attack	_____	☐	☐
- Heart Disease		☐	☐
- Heart Murmur		☐	☐
- Heart Valve Replacement.	_____	☐	☐
- Hepatitis....Type ____	_____	☐	☐
- High Blood Pressure	_____	☐	☐
- High Cholesterol.	_____	☐	☐
- Aids or HIV Infection		☐	☐
- Irritable Bowel Syndrome		☐	☐
- Jaundice	_____	☐	☐
- Joint Replacement. Type_____	_____	☐	☐
- Kidney Disease	_____	☐	☐
- Leukemia	_____	☐	☐
- Low Blood Pressure		☐	☐
- **Mitral Valve Prolapse**		☐	☐
- Osteoporosis	_____	☐	☐
- Radiation Therapy	_____	☐	☐
- Respiratory Problems		☐	☐
- Rheumatic Fever.	_____	☐	☐
- Seasonal Allergies		☐	☐
- Sinus Problems		☐	☐
- STD Type_____		☐	☐
- Stroke	_____	☐	☐
- Thyroid Problems		☐	☐
- Tuberculosis		☐	☐
- Other, Please List_____			

Print Name:_____Date

Patient Signature Date