Time 12:58 PM

Poulsbo Dental Center

Date 12/3/2015

Medical History Form

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you have, or medication that you may be taking, could affect how dental care is delivered. Thank you for answering the following questions.

Have you seen a physician in the last year?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Please list the medications you are taking so we can try to avoid complications with dental treatment	◯ Yes ◯ No	If yes
Include all drugs, pills, injections, vitamins, herbal, patches, homeopathic and smoked products	◯ Yes ◯ No	If yes
Have you had a joint replacement or heart surgery?	◯ Yes ◯ No	If yes
Have you ever taken osteoporosis meds (ie Fosamax, Boniva, Actonel) or other	◯ Yes ◯ No	If yes
Do you use tobacco products? Are you smoking any substance? Are you using vapor or e-cigarettes?	◯ Yes ◯ No	If yes

Women Only: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Specific Metals ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other?	☐	If yes
Do you use any controlled substances?	◯ Yes ◯ No	If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Rhuematic Fever	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Rhuematism	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting or Dizziness	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Learning Disability	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Memory Loss	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack or Failure	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsilitis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmer	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Cortisone Medication	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Psyciatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
Developmental Disability	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No				

Have you ever had any serious illness not listed ◯ Yes ◯ No If yes

Is there anything else you feel we should know about your health and wellness?

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:

X

Date:_____