White River Family Dentistry
Auburn, WA

Patient Name______________________________

MEDICAL/DENTAL HEALTH HISTORY

To receive treatment in this office, you must answer all questions on this history form. The questions asked relate directly to the safe and effective treatment you are to receive in this office. To the best of your ability honest answers must be given. If you are unsure of the question, unsure of the answer, or whether the question relates to your medical condition, you are to discuss the matter with the doctor. Some of the answers may not relate to you or your medical condition, in that event you are to write “N/A” (not applicable) in the space provided. **All questions must be answered.** To properly evaluate your current health status it may be necessary for the dentist to contact your physician.

All information you supply to the office on this form, and the subsequent interview by the dentist and information received from your physician or any other source, will be held in the strictest confidence, and will not be disclosed without your express and written permission.

1. Name, address & telephone # of your physician ____________________
2. Date of last visit to your doctor __________ Purpose of visit ____________________
3. Do you suffer from any disability?_________If yes, describe:____________________
4. Have you ever, or do you now take illegal drugs? ____________________
   If yes, what drugs and when taken: ____________________
   Note: There are several drugs and medications used in routine dental care that are incompatible with several illegal drugs. The effect of the combination may be dangerous to your health and may be fatal.
5. Do you have AIDS, or are you HIV positive? _______ If yes, describe and provide current status:
   ____
6. Do you now have or have you ever had a venereal disease? ______ If yes, describe:
   ____
7. Have you ever had, or do you have hepatitis? _______ If yes, describe:
   ____
8. For females: Are you pregnant? ______ If yes, when are you due?____________________
9. For females: Are you taking birth control pills? _____ Note: There are medications used in routine dental care that decrease the effectiveness of birth control pills.
10. Are you taking any drugs or medications? ______ If yes, list and describe amounts and purpose:
    ____
    ____
    Note: There are many medication incompatibilities, some of which may result in dangerous health problems. Information about your current use of drugs and medications is essential.
11. Have you ever had an allergic reaction to a medication? ______ If yes, describe:
    ____
12. Have you lost weight recently? If yes, describe: ____________________

Have you ever had, or been treated for the following:

13. Rheumatic fever, rheumatic heart disease, heart murmur (e.g. mitrovalve prolapse) or congenital heart disease?
    ____
14. Heart trouble, heart attack, angina, heart surgery, a pacemaker, or irregular beats?
    ____
15. Stomach or intestinal disease? ____________________
16. Abnormal blood pressure, excessive bleeding, or anemia?____________________
17. Breathing problems, asthma, tuberculosis, or hay fever? ____________________
18. Cancer, x-ray treatments, chemotherapy? ____________________
19. Diabetes? ____________________
20. Kidney problems or renal dialysis? ____________________
21. A stroke, convulsions, or fainting spells? ____________________
22. Tumors or growths? ____________________
23. Arthritis or rheumatism? ____________________
24. Have you ever had a major operation? If yes, describe: ____________________
25. Have you ever had a serious injury to your head or neck? If yes, describe:
    ____
26. Are you on a special diet? If yes, for what reason and describe: ____________________

27. Do you smoke? If yes, describe type and quantity: ____________________

28. Have you ever been consulted or been treated by a psychiatrist, psychologist, or counselor: If yes, describe:
____

29. Are there any other problems/concerns with your health of which you are aware?
____

Dental History

Date of your last visit to a dentist:____________________

Reason for your last visit (or series of visits):____________________

Do you have any of your x-rays or dental records? ____________________

In respect to any previous dental treatment, have you:

30. Ever fainted? ____________________
31. Had an allergic reaction? ____________________
32. Had abnormal bleeding? ____________________
33. Any other complications during or following dental treatment? If yes, describe:
____
34. Do your gums bleed when brushing or eating? ____________________
35. Does food catch between your teeth? ____________________
36. Have your teeth shifted, are there spaces between your teeth now where there were none, are your teeth flaring, or are some of your teeth becoming loose?
____
37. Are any of your teeth sensitive to heat, cold, or pressure? ____________________
38. Do you grind your teeth or clench your jaws? ____________________
39. Do you have pain or clicking in the jaw joint around your ear?____________________
40. Have your jaw muscles ever been sore? If yes, describe: ____________________
41. Are there any sores or growths in your mouth? ____________________
42. Do any of your teeth ache? ____________________
43. Do you have any other dental complaints? ____________________

NOTE: A change in your health status should be reported to the office at the earliest possible time.
To the best of my knowledge, the foregoing questions have been accurately answered.

Permission to Release Health Information:
I hereby grant the right to the dentist to release information obtained from me, and information about my dental treatment to third party payors, and/or health practitioners.

Person completing the form:

Signature____________________
Print Name____________________
If other than patient, indicate relationship____________________
Date____________________

Dentist's Review & Significant Findings
____
____
____
____

Doctor's Signature ____________________ Date: ____________________