

Chinook Falls Dental Clinic PC Medical History(Current 7-14)

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 may have, or medication that you may be taking, could have an important interaction with the dental care you will receive. Thank you for answering the following:

Are you under a physician's care now? Yes No If yes

Are you pregnant, trying to get pregnant or think you may be pregnant? Yes No

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

Do you use medical marijuana or any controlled substances? Yes No If yes

Do you take, or have you taken, Phen-Fen or Redux? Yes No If yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes

Are you taking a blood thinner? (e.g., Warfarin, Coumadin, etc?) Yes No If yes

If yes, do you know your INR? Yes No If yes

Are you taking any prescription or non prescription medication, including vitamins? Yes No If yes

Medications continued:

Do you use tobacco or nicotine products?

Cigarettes Yes No | E-Cigarettes Yes No | Chewing Tobacco Yes No | Cigars or Pipes Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic
 Metal Latex Sulfa Drugs Local Anesthetics

Other Allergy? Yes No If yes

Have you been diagnosed with Diabetes?

Yes No

If yes, do you know your most recent A1C/eAG # Yes No If yes

Preprandial Yes No If yes

Postprandial Yes No If yes

Do you have an artificial joint?

Artificial Joint Yes No | Has doctor recommended pre-medication? Yes No

Have you been diagnosed with cancer?

Cancer Yes No | Chemotherapy Yes No | Radiation Treatment Yes No

Have you been diagnosed with Heart problems, or have you had any of the following?

Angina	<input type="radio"/> Yes <input type="radio"/> No	Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No	Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No
High/Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	Bacterial Endocarditis	<input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease	<input type="radio"/> Yes <input type="radio"/> No
Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure	<input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever	<input type="radio"/> Yes <input type="radio"/> No

Have you been diagnosed with Lung complications?

Asthma	<input type="radio"/> Yes <input type="radio"/> No	Emphysema	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No		
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Have you been diagnosed with Liver complications?

Cirrhosis	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C	<input type="radio"/> Yes <input type="radio"/> No		
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Have you been diagnosed with a neurological disorder?

Alzheimer's Disease	<input type="radio"/> Yes <input type="radio"/> No	Parkinson's Disease	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care	<input type="radio"/> Yes <input type="radio"/> No
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Have you experienced any of the following conditions?

Anaphylaxis	<input type="radio"/> Yes <input type="radio"/> No	Breathing Problems	<input type="radio"/> Yes <input type="radio"/> No	Bruise Easily	<input type="radio"/> Yes <input type="radio"/> No	Cold Sores/Fever Blisters	<input type="radio"/> Yes <input type="radio"/> No
Dry Mouth	<input type="radio"/> Yes <input type="radio"/> No	Drug Addiction	<input type="radio"/> Yes <input type="radio"/> No	Easily Winded	<input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding	<input type="radio"/> Yes <input type="radio"/> No
Excessive Thirst	<input type="radio"/> Yes <input type="radio"/> No	Fainting Spells	<input type="radio"/> Yes <input type="radio"/> No	Frequent Cough	<input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea	<input type="radio"/> Yes <input type="radio"/> No
Frequent Headaches	<input type="radio"/> Yes <input type="radio"/> No	Hay Fever	<input type="radio"/> Yes <input type="radio"/> No	Hives or Rash	<input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No
Pain in Jaw Joints	<input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss	<input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No	Sleep Apnea	<input type="radio"/> Yes <input type="radio"/> No
Swelling of Limbs	<input type="radio"/> Yes <input type="radio"/> No						

Have you ever been diagnosed with, or experienced, any of the following?

AIDS/HIV positive	<input type="radio"/> Yes <input type="radio"/> No	Arthritis/Gout	<input type="radio"/> Yes <input type="radio"/> No	Blood Clots	<input type="radio"/> Yes <input type="radio"/> No	GERD	<input type="radio"/> Yes <input type="radio"/> No
Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Herpes/HSV-2	<input type="radio"/> Yes <input type="radio"/> No	High Cholesterol	<input type="radio"/> Yes <input type="radio"/> No	Intestinal Disease	<input type="radio"/> Yes <input type="radio"/> No
Organ Transplant	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease	<input type="radio"/> Yes <input type="radio"/> No	Peripheral Neuropathy	<input type="radio"/> Yes <input type="radio"/> No
Shingles	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths	<input type="radio"/> Yes <input type="radio"/> No
Ulcers	<input type="radio"/> Yes <input type="radio"/> No	Venereal Disease/STDs	<input type="radio"/> Yes <input type="radio"/> No				

Have you had any serious illness not listed above? Yes No If yes

Comments:

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: _____