- ❒ Colville Community Dental Clinic
- ❒ Lake Spokane Community Dental Clinic
- ❒ Springdale Community Dental Clinic

N.E. WASHINGTON HEALTH PROGRAMS

Dental Medical History Form

Patient Name: ________________________________ **Birthdate:** ____________________ **Date:** ______________

Please check the 'Yes' or 'No' box for any condition that you have had in the past or have now.

(**PARENTS OR GUARDIAN:** If you are completing this form for your child, please indicate your child's health status by checking the appropriate box**.**)

1 CARDIOVASCULAR	Yes	No
Heart failure	☐	☐
Heart disease or attack	☐	☐
Angina pectoris or chest pain	☐	☐
High blood pressure	☐	☐
Heart murmur	☐	☐
Mitral valve prolapse	☐	☐
Scarlet fever	☐	☐
Rheumatic fever	☐	☐
Congenital heart defect or lesion	☐	☐
Artificial heart valve	☐	☐
Arrhythmias	☐	☐
Heart pacemaker or defibrillator	☐	☐
Heart surgery or transplant	☐	☐
Other heart problems	☐	☐
Stroke	☐	☐
Aneurysm	☐	☐

2 HEMATOLOGIC		
Blood transfusion	☐	☐
Anemia	☐	☐
Hemophilia	☐	☐
Leukemia	☐	☐
Sickle cell (anemia) disease	☐	☐
Bleed longer than normal	☐	☐

3 NEURAL AND SENSORY		
Eye pain	☐	☐
Vision problems	☐	☐
Glaucoma	☐	☐
Hearing loss	☐	☐
Severe headaches	☐	☐
Fainting or dizzy spells	☐	☐
Epilepsy or seizures	☐	☐
Nervousness	☐	☐
Psychiatric treatment	☐	☐
Fibromyalgia	☐	☐

4 GASTROINTESTINAL	Yes	No
Stomach/intestinal ulcers	☐	☐
Gastritis	☐	☐
Colitis	☐	☐
Persistent diarrhea	☐	☐
Hepatitis: Type ____________	☐	☐
Liver disease	☐	☐
Yellow Jaundice	☐	☐
Cirrhosis	☐	☐

5 RESPIRATORY		
Hay fever	☐	☐
Sinus trouble	☐	☐
Allergies or hives	☐	☐
Asthma	☐	☐
Persistent/bloody cough	☐	☐
Emphysema	☐	☐
Tuberculosis (TB)	☐	☐
Breathing difficulties	☐	☐

6 DERMAL MUCOCUTANEOUS MUSCULOSKELETAL		
Allergy to latex (rubber)	☐	☐
Skin rash	☐	☐
Night sweats	☐	☐
Arthritis	☐	☐
Artificial joint	☐	☐
Fever blister; cold sore	☐	☐
Mouth ulcers or canker sores	☐	☐
Colored or discolored areas in mouth	☐	☐

WOMEN'S HEALTH		
Are you pregnant?	☐	☐
Due Date: ______________		
Are you breast feeding?	☐	☐
Are you taking birth control?	☐	☐

7 ENDOCRINE	Yes	No
Diabetes: Type __________	☐	☐
Kidney disease	☐	☐
Dialysis or vascular grafts	☐	☐
Thyroid disease	☐	☐

8 URINARY – SEXUALLY TRANSMITTED		
Urinate frequently	☐	☐
Kidney, bladder problem	☐	☐
Sexually transmitted disease (syphilis, gonorrhea, chlamydia, etc.)	☐	☐
HIV positive	☐	☐

9 OTHER CONDITIONS		
Organ transplant	☐	☐
Frequent sore throat	☐	☐
Enlarged lymph node or "gland"	☐	☐
Use tobacco	☐	☐
Use alcohol	☐	☐
Drug or alcohol dependence (recovering or current)	☐	☐
Tumor or cancer	☐	☐
Radiation treatment	☐	☐
Chemotherapy	☐	☐
Lupus	☐	☐
Disease, problem or condition not listed?	☐	☐

If yes, please list:

____

____

____

____

____

____

____

____

Patient Name: ________________________ **Birthdate:** ________________ **Date:** ____________

		Yes	No
1.	Are you currently under the care of a physician? Physician's Name: ____________ Phone Number: ____________ Address: ____________		
2.	Have you received any medical/health treatment in the last two years? ____________		
3.	Have you been hospitalized for care or surgery? ____________		
4.	Do you, or have you experienced any of the following? ☐ Chest pain or pressure. ☐ Shortness of breath with mild exercise (such as walking up a flight of stairs). ☐ Shortness of breath when lying down. ☐ Swelling of the ankles. ☐ Unintentionally gained or lost ten or more pounds within the last year.		
5.	Have you taken Cortisone, Prednisone or other steroids in the last 2 years?		
6.	Have you taken any diet medication such as Fen-phen or other?		
7.	Have you had any complications with previous dental treatment? ____________		
8.	Are you allergic or have you reacted adversely to penicillin or other antibiotics, local anesthetics, codeine or other narcotics, aspirin, latex or other? ____________		

Medications: Include all prescription drugs, non- prescription drugs, herbal medicines and any recreational drugs.

____

____

____

____

Dental History:

Describe your dental problem or concern: ____________

Mark all that apply to you:

- ☐ Pain in teeth
- ☐ Pain in mouth
- ☐ Previous injury to head, neck or face
- ☐ Interested in quitting tobacco use
- ☐ Pain in gums
- ☐ Interested in braces
- ☐ Concerned about materials used for fillings
- ☐ Pain in TMJ (jaw joint)
- ☐ Anxious about dental care
- ☐ Concerned about fluoride

To the best of my knowledge, all the answers on this page and the preceding page are true and correct. If I ever have any change in my health, abnormal laboratory test, or if my medicines change, I will inform the dentist at the next appointment without fail.

____________ Date

____________ Patient, Parent or Guardian Signature

____________ Dentist Signature

FOR OFFICE USE ONLY

Date: ________ Ht: ______ Wt: ______ BP: ______ Pulse: ______ Resp: ______ Initials: ________

Date	Changes in Medical History	Pt. Signature	Dentist Signature