Dupont Family Dentistry
Dupont, 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: _____