SEATTLE SPECIAL CARE DENTISTRY™

Medical History

It is very important to answer all questions truthfully and to the best of your knowledge so that we can best plan your dental care and avoid any unnecessary personal health risks. Please assist us by completing the following, and let us know if you do not understand any part of this form:

Name:					Today's Date:
How do you describe your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor				What do you consider to be your most important health issues?	
Birth date:	Age:	Height:	Weight:	Who is your personal physician?	Physician's telephone:

Have you ever had or been treated for any of the following diseases/conditions? **Please check Yes or No and circle all that apply.** Thank you.

Yes ☐ No ☐ **HEART**
- Congestive heart failure
- Congenital heart malformation
- Valve problems / murmur
- Chest pain / angina
- Heart attack / myocardial infarct
- Cardiac arrhythmia
- Pacemaker / defibrillator / VAD

Yes ☐ No ☐ **VASCULAR**
- High / Low blood pressure
- Fainting / dizzy spells
- Central venous catheter / PICC
- Stroke, TIA

Yes ☐ No ☐ **BLEEDING DISORDERS**
- Hemophilia
- Anticoagulants
- Bruise easily
- Low / high platelets
- Anemia
- Transfusions
- Sickle cell disease

Yes ☐ No ☐ **LUNGS**
- Asthma, Bronchitis, Emphysema
- Pulmonary fibrosis / scarring
- Chronic cough, short of breath
- Pneumonia, tuberculosis
- Obstructive Sleep Apnea

Yes ☐ No ☐ **LIVER**
- Hepatitis (A,B,C, Autoimmune)
- Jaundice
- Cirrhosis, alcoholism

Yes ☐ No ☐ **DIGESTIVE TRACT**
- Diet (special/ restricted)
- Ulcers / GI Bleeding
- Gastric Reflux / Heartburn
- Colitis, Crohns, IBS
- Constipation / diarrhea
- Esophagus disease

Yes ☐ No ☐ **KIDNEY**
- Hemodialysis
- Peritoneal dialysis
- Acute or chronic Renal failure
- Polycystic

Yes ☐ No ☐ **HORMONES**
- Thyroid problems
- Diabetes / Pancreas disease
- Pituitary / Adrenal
- Gender hormone issues

Yes ☐ No ☐ **MUSCLES/SKELETON**
- Osteoporosis
- Artificial joints (hip, knee, etc.)
- Multiple sclerosis
- Myasthenia Gravis
- Muscular Dystrophy
- Trauma
- Swollen ankles

Yes ☐ No ☐ **IMMUNOLOGIC**
- Lupus
- Other autoimmune disease
- Immunosuppressive therapy
- Use of prednisone or similar

Yes ☐ No ☐ **CANCER** (Type: _______________)
- Radiation therapy
- Chemotherapy
- Surgery

Yes ☐ No ☐ **PSYCHIATRIC**
- Psychiatric / Psychologic care
- Nervous / anxious
- Depression
- Developmental delay / autism
- Behavior issues
- Learning disability
- Alzheimer's / Dementia

Yes ☐ No ☐ **NEUROLOGIC**
- Seizures / Epilepsy
- Parkinson's
- Cerebral palsy

Yes ☐ No ☐ **INFECTIOUS DISEASE**
- HIV+
- Sexually transmitted disease
- Other infectious disease

Yes ☐ No ☐ **HEAD**
- Sinus trouble / Hay fever
- Migraine headaches
- Cold sores/ fever blisters
- Vision / hearing impairment

Yes ☐ No ☐ **HABITS**
- Tobacco (cigarettes, cigars, snuff)
- Alcohol (social, heavy, alcoholism)
- Drug abuse (street / prescription)

Women: Some medications used in dentistry will cross the placenta and breast milk, and might affect the unborn fetus. Antibiotic use may reduce the effectiveness of birth control pills, and alternate methods are recommended if taking them.

Are you pregnant? ☐Yes, ______ Months ☐No ☐Possibly or Not sure

Do you use birth control pills or injection? ☐Yes ☐No

Are you breastfeeding? ☐Yes ☐No

Using hormone replacement therapy (HRT)? ☐Yes ☐No

Please describe any conditions not listed, or use this space to give details about any of your medical issues:

(OVER)

Please list all medications you are currently taking. Be sure to include over-the-counter and herbal products: (attach extra paper if necessary)		
Name	Dose / How often	Reason for taking

Please list all operations you have had:

Please list any allergies and/or bad reactions you have had:

☐ **NO KNOWN ALLERGIES**	To what	What happens?	How severe?

Would you care to speak to the dentist privately about any health issues? ☐ ***Yes*** ☐ ***No***

I have read and understand the questions on the health history. I have answered them to the best of my ability.

Signature of patient:	Date:
Signature of Legal Guardian, if applicable:	Date:
Legal Guardian's relationship to patient:	

Doctor's use:	VS: B/P P SpO_2
	Exercise Tolerance (if applicable):