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	
		VASCULAR	
		High / Low blood pressure	
		Fainting / dizzy spells	
		Central venous catheter / PICC	
		Stroke, TIA	
		BLEEDING DISORDERS	
		Hemophilia	
		Anticoagulants	
		Bruise easily	
		Low / high platelets	
		Anemia	
		Transfusions	
		Sickle cell disease	
		LUNGS	
		Asthma, Bronchitis, Emphysema	
		Pulmonary fibrosis / scarring	
		Chronic cough, short of breath	
		Pneumonia, tuberculosis	
		Obstructive Sleep Apnea	
		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	
		KIDNEY	
		Hemodialysis	
		Peritoneal dialysis	
		Acute or chronic Renal failure	
		Polycystic	
		HORMONES	
		Thyroid problems	
		Diabetes / Pancreas disease	
		Pituitary / Adrenal	
		Gender hormone issues	
		MUSCLES/SKELETON	
		Osteoporosis	
		Artificial joints (hip, knee, etc.)	
		Multiple sclerosis	
		Myasthenia Gravis	
		Muscular Dystrophy	
		Trauma	
		Swollen ankles	
		IMMUNOLOGIC	
		Lupus	
		Other autoimmune disease	
		Immunosuppressive therapy	
		Use of prednisone or similar	

Yes	No		
		CANCER (Type: _____)	
		Radiation therapy	
		Chemotherapy	
		Surgery	
		PSYCHIATRIC	
		Psychiatric / Psychologic care	
		Nervous / anxious	
		Depression	
		Developmental delay / autism	
		Behavior issues	
		Learning disability	
		Alzheimer's / Dementia	
		NEUROLOGIC	
		Seizures / Epilepsy	
		Parkinson's	
		Cerebral palsy	
		INFECTIOUS DISEASE	
		HIV+	
		Sexually transmitted disease	
		Other infectious disease	
		HEAD	
		Sinus trouble / Hay fever	
		Migraine headaches	
		Cold sores/ fever blisters	
		Vision / hearing impairment	
		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):