



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? <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> 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.

<p>Yes <input type="checkbox"/> No <input type="checkbox"/> HEART Congestive heart failure Congenital heart malformation Valve problems / murmur Chest pain / angina Heart attack / myocardial infarct Cardiac arrhythmia Pacemaker / defibrillator / VAD</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> VASCULAR High / Low blood pressure Fainting / dizzy spells Central venous catheter / PICC Stroke, TIA</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> BLEEDING DISORDERS Hemophilia Anticoagulants Bruise easily Low / high platelets Anemia Transfusions Sickle cell disease</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> LUNGS Asthma, Bronchitis, Emphysema Pulmonary fibrosis / scarring Chronic cough, short of breath Pneumonia, tuberculosis Obstructive Sleep Apnea</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> LIVER Hepatitis (A,B,C, Autoimmune) Jaundice Cirrhosis, alcoholism</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/> DIGESTIVE TRACT Diet (special/ restricted) Ulcers / GI Bleeding Gastric Reflux / Heartburn Colitis, Crohns, IBS Constipation / diarrhea Esophagus disease</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> KIDNEY Hemodialysis Peritoneal dialysis Acute or chronic Renal failure Polycystic</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> HORMONES Thyroid problems Diabetes / Pancreas disease Pituitary / Adrenal Gender hormone issues</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> MUSCLES/SKELETON Osteoporosis Artificial joints (hip, knee, etc.) Multiple sclerosis Myasthenia Gravis Muscular Dystrophy Trauma Swollen ankles</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> IMMUNOLOGIC Lupus Other autoimmune disease Immunosuppressive therapy Use of prednisone or similar</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/> CANCER (Type: _____) Radiation therapy Chemotherapy Surgery</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> PSYCHIATRIC Psychiatric / Psychologic care Nervous / anxious Depression Developmental delay / autism Behavior issues Learning disability Alzheimer's / Dementia</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> NEUROLOGIC Seizures / Epilepsy Parkinson's Cerebral palsy</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> INFECTIOUS DISEASE HIV+ Sexually transmitted disease Other infectious disease</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> HEAD Sinus trouble / Hay fever Migraine headaches Cold sores/ fever blisters Vision / hearing impairment</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> HABITS Tobacco (cigarettes, cigars, snuff) Alcohol (social, heavy, alcoholism) Drug abuse (street / prescription)</p>
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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:

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
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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

SpO₂

Exercise Tolerance
(if applicable):