Powder River Dental Medical History

Patient Name: ____________________

Dental personnel primarily treat the area in and around your mouth, however your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, can have an important interrelationship with dental treatment. Thank you for answering the following questions.

Do you have a primary care doctor?	☐ Yes ☐ No	Doctor:
Are you taking any blood thinners? *(i.e. Aspirin, Warfarin/Coumadin, Eliquis, Xarelto etc.)*	☐ Yes ☐ No	Name:
Have you ever taken any medications containing bisphosphonates? *(i.e. Fosamax, Boniva, Actonel etc.)*	☐ Yes ☐ No	Name & Duration:
Have you been hospitalized in the past year?	☐ Yes ☐ No	Why:
Have you ever had a major operation/surgery?	☐ Yes ☐ No	What:

Please list all medications *(including any supplements)* that you are taking: List: ____________________

Tobacco/Alcohol/Drug Use:

Do you use smokeless tobacco?	☐ Yes ☐ No	
Do you Vape or use E-Cigarettes?	☐ Yes ☐ No	
Do you Smoke?	☐ Yes ☐ No	If yes, how many packs per day and for how many years?
Do you drink alcohol?	☐ Yes ☐ No	If yes, on average how many drinks per week?
Do you use recreational drugs?	☐ Yes ☐ No	History?

Women:

☐ Are you or could you be pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following:

☐ Aspirin ☐ Penicillin ☐ Codeine/Narcotics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetic ☐ Other?

Do you have, or have you ever had any of the following conditions?

Cardiovascular

☐ Angina/Chest Pain	☐ Artificial Heart Valve*	☐ Congenital Heart Disease	☐ Heart Attack
☐ Heart Failure	☐ Heart Murmur	☐ Heart Stent	☐ High Blood Pressure
☐ High Cholesterol	☐ Infective Endocarditis*	☐ Irregular Heart Beat	☐ Low Blood Pressure
☐ Mitral Valve Prolapse	☐ Pacemaker	☐ Rheumatic Fever	☐ Stroke/Paralysis

Respiratory

☐ Asthma	☐ Emphysema	☐ Oxygen Dependent	☐ Shortness of Breath

Gastro-Intestinal

☐ Dialysis	☐ GERD	☐ Intestinal Disease	☐ Kidney Disease
☐ Liver Disease/Jaundice	☐ Stomach Disease		

Neurology

☐ Alzheimers/Dementia	☐ Convulsions/Seizures	☐ Epilepsy	☐ Fainting/Dizziness
☐ Psychiatric Treatment			

Endocrine

☐ Cortisone Medication	☐ Diabetes Type 1 *(Insulin Dependent)*	☐ Diabetes Type 2	☐ Hypoglycemia
☐ Steroid Treatment	☐ Thyroid Disease		

Hematology

☐ Anemia	☐ Autoimmune Disease	☐ Bleeding/Bruise Easily	☐ Blood Disorder
☐ Hemophilia	☐ Lupus	☐ Sickle Cell Disease	☐ Sjogren's

Infectious Disease

☐ COVID 19	☐ Hepatitis B *(not the vaccine)*	☐ Hepatitis C	☐ Herpes
☐ HIV/AIDS	☐ Scarlet Fever	☐ Sexually Transmitted Infection	☐ Tuberculosis

Musculoskeletal

☐ Artificial Joint *(describe below)*	☐ Gout	☐ Osteoporosis	☐ Rheumatism

General

☐ Cancer *(describe below)*	☐ Chemotherapy	☐ Drug/Alcohol Treatment	☐ Fen-Phen Use
☐ Glaucoma	☐ Hives/Rash	☐ Radiation Therapy	☐ Recent Weight Gain/Loss
☐ Sleep Apnea	☐ Snoring	☐ Tumors or Growths	

Do you have any other medical conditions not listed? ____________________

Please provide any supplemental information or details that may be relevant to your treatment:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian **Date**