KIRKLAND DENTAL **HEALTH HISTORY** ***FAMILY & COSMETIC DENTISTRY***

Patient Name: ______________________ Sex: ________ Weight: ____________ Height: ____________

Physician Name: ______________________ Physician Phone: ______________________

Pharmacy Name: ______________________ Pharmacy Phone: ______________________

A. GENERAL: Please circle Yes (Y) or No (N)

1. Y N Have there been any changes in your general health within the last year?
2. Y N Have you ever had surgery or a serious illness?
3. Y N Are you being treated by a doctor? Date of last visit:____________
4. Y N Have you been or are you being treated for chemical or alcohol dependency?
5. Y N Do you often feel sad, tired, depressed, anxious, angry?
6. Y N Received psychiatric care?

Do you now have or have you ever had any of the following:

6. Y N Diabetes TYPE ____________
7. Y N Liver condition (hepatitis TYPE____, cirrhosis, jaundice)
8. Y N Kidney condition
9. Y N Hypothyroidism, hyperthyroidism
10. Y N Persistent or painful swollen glands
11. Y N Arthritis, rheumatism
12. Y N Prosthetic joints or implants
13. Y N Back or neck problems, SPECIFY: ________________
14. Y N HIV
15. Y N Cancer, SPECIFY: ____________ ❑ radiation ❑ chemo
16. Y N Seizures
17. Y N Fainting or dizziness
18. Y N Glaucoma
19. Y N Headaches or migraines
20. Y N Autoimmune disease, SPECIFY: ________________
21. Y N WOMEN ONLY: Is it likely that you are pregnant?

B. HEART & CIRCULATION: Do you now have or have you ever had any of the following:

1. Y N Heart murmur, mitral valve prolapse, congenital heart disease
2. Y N Rheumatic fever, rheumatic heart disease, scarlet fever
3. Y N Atrial fibrillation
4. Y N Heart attack, bypass surgery, angina
5. Y N High blood pressure, low blood pressure
6. Y N Swelling of feet or ankles
7. Y N Congestive heart failure
8. Y N Stroke
9. Y N Pacemaker, artificial valves, shunts or blood vessels
10. Y N Hemophilia or blood clotting disorder
11. Y N Anemia
12. Y N Bacterial endocarditis (SBE)

C. LUNGS & RESPIRATION: Do you now have or have you ever had any of the following:

1. Y N Chronic lung disease, COPD
2. Y N Asthma
3. Y N Emphysema
4. Y N Tuberculosis (TB)
5. Y N Sinus or ear trouble
6. Y N Persistent or bloody cough
7. Y N Shortness of breath
8. Y N Do you use oxygen or a nightly CPAP/BIPAP device?

D. MEDICATIONS & ALLERGIES: Have you had allergic or adverse reactions to any of the following:

❑ Penicillin or other antibiotics
❑ Pain medication, SPECIFY: ____________________
❑ Barbiturates, SPECIFY: ____________________
❑ Latex ❑ Aspirin ❑ Sulfa ❑ Acrylic
❑ Iodine ❑ Coconut ❑ Meta ❑ Metals
❑ NO KNOWN ALLERGIES
❑ Other: ______________________________

Have you ever taken:

1. Y N Weight loss medications (e.g., Phen Fen, Redux, Pondimin)
2. Y N Bisphosphonates (osteoporosis or hypercalcemia) (e.g., Fosamax, Actonel, Boniva, Reclast/Zometa, Aredia, Prolia)
3. Y N Cortisone or steroid treatment

Do you now have or have you ever had any of the following:
(PLEASE COMPLETE LIST ON PAGE 2)

4. Y N Prescription drugs
5. Y N Over-the-counter or herbal medications

Other medical conditions not listed above:______________________________

STOP-BANG Questionnaire (for obstructive sleep apnea)
Please answer the following questions by checking Yes or No for each one

	Yes	No
Snoring (Do you snore loudly?)	❑	❑
Tiredness (Do you often feel tired, fatigued, or sleepy during the daytime?)	❑	❑
Observed apnea (Has anyone observed that you stop breathing, choke or gasp during your sleep?)	❑	❑
High Blood **P**ressure (Do you have or are you being treated for high blood pressure?)	❑	❑
BMI (Is your body mass index more than 35 mg per m^2?)	❑	❑
Age (Are you older than 50 years?)	❑	❑
Neck Circumference (Is your neck circumference greater than 40 cm (15.75 inches)?)	❑	❑
Gender (Are you male?)	❑	❑

I certify the information on BOTH pages herein is correct and authorize its release as required for the administration of my treatment.

______________________ ____________ ______________________
Signature of Patient, Parent or Guardian *Date* *Signature of Dentist or RDH*

CHECK-IN SCREENING:	
Temperature	°F
Blood Oxygen Level	%

VITAL SIGNS:	
Blood Pressure	mmHg
Pulse Rate	bpm

Patient Name: ____

E. DENTAL HISTORY:

1. Y N Have you ever taken antibiotic premedication before dental treatment?
2. Y N Any serious adverse reactions to local anesthetic?
3. Y N Any serious problems with previous dental treatment?
4. Y N Are you now fearful or worried about receiving treatment? SPECIFY TRIGGER______________________
5. Y N Are your teeth sensitive to hot, cold, sweet, sour?
6. Y N Does food get caught in a specific spot(s)?
7. Y N Do you have loose teeth?
8. Y N Are your gums sore or bleeding?
9. Y N Does your mouth or tongue burn?
10. Y N Do you have pain or difficulty chewing, opening wide or jaws locking open/closed?
11. Y N Is there anything you would change about your smile?
12. Y N Do you have frequent mouth sores or blisters? How often? ________________________________
13. Y N Have you ever had treatment for severe periodontal disease (gum disease) such as a "deep cleaning?"
14. Y N Have you ever had orthodontic treatment (braces) or dental/oral surgery?
15. Y N Do you wear a night guard? FREQUENCY: ___________
16. How often do you brush? _______________ Floss? ___________

Oral habits:

❑ Clenching ❑ Grinding ❑ Snoring ❑ CPAP ❑ Mouth Breathing
❑ Nail biting ❑ Cheek/lip biting or chewing
❑ Smokeless tobacco - HOW MUCH? ________ HOW LONG? _______
❑ Smoking (including cigarettes, MJ, or vaping) - HOW MUCH? ___________________/day HOW LONG? _______

MEDICATION LIST: *Please list prescription, herbal, AND over-the-counter medications*

Name of Medication	Reason for Taking	Strength	Amount Taken	Frequency Taken