

Snoqualmie Ridge Family Dental
Medical & Dental Health History

In order to serve you effectively and safely, please complete the questionnaire to the best of your knowledge. This is a confidential record of your medical history. Your information will not be released without your permission.

Patient Name: _____ Date of birth: _____ Today's date: _____

Medical History

How would you rate your general health? Excellent Good Fair Poor Height: _____ Weight: _____

Within the last year, are there any changes in your general health? No Yes: _____

Within the last five years, have you been hospitalized or undergone any surgery or blood transfusion? No Yes: _____

What is the name (or clinic) of your primary care physician? If none, please put N/A. _____

What is the date (or approximate date) of your last medical exam or visit? _____

Do you have any known allergies? Please select all that apply. No known drug allergies

- | | |
|---|---|
| <input type="checkbox"/> Penicillin, amoxicillin, and related antibiotics | <input type="checkbox"/> Local anesthetics |
| <input type="checkbox"/> Antibiotics containing sulfanomides (sulfa drugs) | <input type="checkbox"/> Latex (rubber) |
| <input type="checkbox"/> Aspirin, ibuprofen, and other non-steroidal anti-inflammatory drugs (NSAIDs) | <input type="checkbox"/> Seasonal/hay fever |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Anticonvulsants |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Metal(s) _____ |

Are you currently taking prescription medications? No Yes: _____

Are you currently taking non-prescription or over-the-counter (OTC) medications? No Yes: _____

Are you currently taking vitamins, supplements, or herbal medicine? No Yes: _____

Have you had an orthopedic total joint replacement (hip, knee, elbow, finger, etc)? No Yes

- Approximate month and year of the orthopedic surgery: _____
- Have you had any complications? No Yes: _____

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax, Actonel, Atelvia, Boniva, Reclast, Prolia) for osteoporosis or Paget's disease? No Yes

Were you treated or are you scheduled to begin treatment with an antiresorptive agent (like Aredia, Zometa, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?

No Yes

Do you have any of the following conditions?

- | | |
|---|--|
| <input type="checkbox"/> I do not have congenital heart disease, artificial heart valve, or previous infective endocarditis | |
| <input type="checkbox"/> Artificial (prosthetic) heart valve | <input type="checkbox"/> Repaired congenital heart disease that was completed in the last 6 months |
| <input type="checkbox"/> Damaged valves in transplanted heart | <input type="checkbox"/> Repaired congenital heart disease with residual defects |
| <input type="checkbox"/> Previous infective endocarditis | <input type="checkbox"/> Unrepaired, cyanotic congenital heart disease |

Do you have any bleeding/blood disorder, such as anemia, hemophilia, sickle cell disease, Von Willebrand disease?

No Yes Other: _____

Are you taking any blood thinners, such as anticoagulants (warfarin/Coumadin or heparin) or antiplatelet (such as aspirin)?

No Yes Other: _____

Have you had abnormal bleeding associated with previous extraction, surgery, or trauma? No Yes

Do you bruise easily? No Yes Have you ever required a blood transfusion? No Yes

Do you have or have you had any of the following conditions or symptoms? Please select all that apply.

- | | |
|--|--|
| <input type="checkbox"/> I do not have any of the following conditions or symptoms | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Bronchitis (acute or chronic) | <input type="checkbox"/> Persistent cough lasting greater than 3 weeks |
| <input type="checkbox"/> Chronic obstructive pulmonary disease (COPD) | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cough that produces blood | |

Do you have or have you had any of the following conditions or symptoms? Please select all that apply.

- I do not have any of the following conditions or symptoms
- Angina, chest pain or pressure
- Arrhythmia (abnormal rhythm), palpitation, irregular heartbeats
- Chest pain upon exertion
- Heart attack
- High blood pressure or hypertension
- Other congenital heart defects
- Pacemaker
- Rheumatic heart disease, rheumatic fever
- Shortness of breath

Do you have or have you had any of the following conditions? Please select all that apply.

- I do not have any of the following conditions
- Acid reflux, heartburn, gastroesophageal reflux disease (GERD)
- Crohn's disease
- Diverticular disease
- Dysphagia, difficulty swallowing, choke on food
- Peptic ulcer disease

Do you have or have you had any of the following conditions? Please select all that apply.

- I do not have any of the following conditions
- Adrenal insufficiency or Addison's Disease
- Cushing's Syndrome
- Grave's Disease
- Diabetes – type I or II
- Hashimoto's Disease
- Hyperthyroidism (overactive thyroid)
- Hypothyroidism (underactive thyroid)

Do you have or have you had any of the following conditions? Please select all that apply.

- I do not have any of the following conditions
- Arthritis
- Autoimmune disorder
- Cancer/chemotherapy/radiation treatment
- Chronic pain
- Eating disorder
- Epilepsy
- Hepatitis
- HIV/AIDS
- Kidney disease
- Mental health conditions, such as depression, anxiety, phobia
- Neurological disorder
- Organ transplant
- Osteoporosis
- Recurrent infections
- Rheumatoid arthritis
- Seizures or fainting spells
- Severe headache/migraine
- Sexually transmitted disease
- Sinus trouble
- Systemic lupus erythematosus

Do you have any disease, condition, or problem not listed above that you think we should know about? No Yes: _____

History of tobacco product use: Never Previously, last used: _____ Currently, type/amount: _____

History of recreational drug use: None Currently, type/amount: _____

Dental History

Name of previous dentist: _____ Approximate date of last dental exam: _____

- | | | | | | |
|--|------------------------------|-----------------------------|---|------------------------------|-----------------------------|
| Are you happy with your smile? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have you ever had orthodontic treatment? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you clench or grind your teeth? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do your gums bleed when you brush or floss? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are your teeth sensitive to hot, cold, sweets, or pressure ? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Has your jaw ever locked open or closed? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have any sores or lumps in or around your mouth? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Does your mouth feel dry frequently? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have any pain in your teeth or jaw currently? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you bite your cheeks or lips frequently? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever had any serious injuries to your head, neck, or mouth? | | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever had periodontal (gum) treatments, such as deep cleaning or gingival (gum) graft? | | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever had any problems associated with previous dental treatments? | | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

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 (my child's) health. It is my responsibility to inform the doctor's office of any changes in my (my child's) medical status. I also authorize the healthcare staff to perform the necessary health care services I (my child) may need.

Signature _____

Date _____

Parent/guardian signature if under 18

Last Minute Cancellation, Late Arrival, and No Show Policy

We want to thank you for choosing Snoqualmie Ridge Family Dental (SRFD) for your dental care needs. We strive to provide you with the best possible care in a timely matter. Your scheduled appointment will ensure that you are given a proper amount of time needed for your visit. It is very important that you attend your scheduled appointment on time.

We understand that sometimes there may be emergencies or schedule changes and you may need to reschedule or cancel your appointment. As a courtesy to our office, as well as to those patients who are waiting to schedule with the office, please call the office to reschedule or cancel as soon as possible (with at least a 48-hour notice). This would allow us to offer your cancelled appointment to other patients.

Late arrival, last minute cancellation, or no show will result in a \$100 fee to be charged to your account. Your dental insurance company does not cover this fee. Repeated late arrivals, last minute cancellations, or no shows would affect our ability to provide care for you, and our office may decide to terminate the relationship with you.

- “No show”: if you are not present for your scheduled appointment
- “Last minute cancellation”: cancellation with less than a 48-hour notice
- “Late arrival”: being more than 10 minutes late to the scheduled appointment

I acknowledge that I have read, understand, and agree to SRFD’s Last Minute Cancellation, Late Arrival, and No Show policy. I understand my responsibility to plan appointments accordingly and to notify SRFD appropriately if I cannot keep my scheduled appointments.

Patient Name

Patient Signature

Date