SPECIAL CARE DENTISTRY
— OF OREGON —

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Albany, OR 97321
Phone: 541.926.3689
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Patient Name:______________________________ Date of Birth:______________ Today's Date:______________

DENTAL HISTORY & SYMPTOMS (New Patients Only)

What is the reason for your visit today?

Are you currently experiencing any dental pain or discomfort? ☐ Yes ☐ No If yes, where?

When was your last dental exam? / / What was done at that appointment?

When was the last time you had dental x-rays taken?

How often do you brush? How often do you floss?

Please mark an "X" in the box ONLY if this applies to you.

Is it hard to open your mouth, or do you have limited opening? ☐
Does it hurt to chew, bite or swallow? ☐
Do your gums bleed when you brush or floss? ☐
Have you ever had periodontal (gum) treatment like scaling and root planing? ☐
Do you have, or have you ever had, any sores or growths in your mouth? ☐
Do you clench or grind your teeth? ☐
Does your jaw click, pop or hurt? ☐
Do you have earaches or neck pains? ☐
Does dental treatment make you nervous? ☐
Have you had orthodontic treatment (braces)? ☐
If yes, do you still wear your retainers? ☐
Have you ever experienced any of these sleep related breathing discorders? ☐
☐ Mouth breathing ☐ Snoring ☐ Trouble breathing during sleep ☐ Sleep Apnea
Have you ever had a serious injury to your head or mouth? ☐
If yes, please explain what happened and when: ______________________________

____

Have you ever had problems with dental treatment in the past? ☐
If yes, please describe what happened: ______________________________

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Have you ever had a reaction to, or problem with, dental anesthesia? ☐
If yes, please describe what happened: ______________________________

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Are you unhappy with your smile? ☐
If yes, why? Please mark all that apply: ☐ Color of teeth ☐ Shape of teeth ☐ Position of teeth
Other reason: ______________________________

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MEDICATIONS & OTHER PRODUCTS/SUBSTANCES

Please use an "X" to mark your answers to the following questions.	Yes	No	?
Are you taking any blood thinners (such as Coumadin, Warfarin, rivaroxaban (Xarelto®), dabigatran (Pradaxa®), clopidogrel (Plavix®), heparin or aspirin?	☐	☐	☐
If yes, what medications are you taking? ______			
Are you taking any medications to treat osteoporosis or Paget's disease?	☐	☐	☐
Some commonly prescribed drugs include alendronate (Fosamax®), risendronate (Actonel®), ibandronate (Boniva®), zolendronate (Reclast®), and denosumab (Prolia®)			
If yes, what medications are you taking? ______			
Are you taking, or scheduled to take, an IV medication to treat bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Some commonly prescribed drugs include denosumab (Xgeva®), pamidronate (Aredia®), or zolendronate (Zometa®). If yes, what are you taking? ______			
How many years have you been taking it? ______			
Are you taking hormonal replacements?	☐	☐	☐
Do you use any forms of tobacco or nicotine products (cigarettes, cigars, snuff, chew, bidis)?	☐	☐	☐
Do you use vaping products?	☐	☐	☐
How many alcoholic beverages do you consume per week? ______			
Do you use controlled substances (drugs), including marijuana, for either medical or recreational reasons?	☐	☐	☐
If yes, what substances? ______			
How often is your use? ☐ Daily ☐ Several times per week ☐ Weekly ☐ Occasionally			
Was it prescribed by a doctor? ☐ Yes ☐ No If yes, for what reason(s)? ______			
Are you taking birth control pills?	☐	☐	☐
Are you pregnant? If yes, number of weeks: ______	☐	☐	☐
Are you nursing?	☐	☐	☐

MEDICAL & SURGICAL HISTORY

Date of last physical exam: / / | Primary Care Provider's Name: | Phone:

Other Specialists:

Please use an "X" to mark your answers to the following questions.	Yes	No	?
Are you in good physical health?	☐	☐	☐
Are you currently being seen or treated by a physician?	☐	☐	☐
Has a physician or previous dentist recommended that you take antibiotics before having dental work done?	☐	☐	☐
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐
Have you had any type (total or partial) of joint replacement surgery (hip, knee, shoulder, elbow, etc)?	☐	☐	☐
Have you had a heart valve replacement in heart surgery?	☐	☐	☐
Have you had an organ or bone marrow/stem cell treatment?	☐	☐	☐
Have you traveled internationally within the last 30 days?	☐	☐	☐
Have you had a fever (100.4ºF or above) in the last 72 hours?	☐	☐	☐

If you answered yes to any of the above, please explain: ______

______

______

MEDICAL HISTORY SPECIFICS

Please use an "X" to mark if you have a current diagnosis or history of the following:

Cardiovascular Health
- Anemia ☐
- Artificial (Prosthetic) heart valve ☐
- Arteriosclerosis ☐
- Atrial fibrillation (a-fib) ☐
- Abnormal bleeding ☐
- Blood clot ☐
- Blood transfusion ☐
- Congenital heart disease (CHD) ☐
  - Unrepaired, cyanotic (CHD) ☐
  - Reparied (completely) last 6 months ☐
  - Repaired CHD with residual defects ☐
- Congestive heart failure ☐
- Coronary artery disease ☐
- Damaged heart valve ☐
- Heart attack ☐
- Heart murmur ☐
- Heart rhythm disorder ☐
- High blood pressure ☐
- High cholesterol ☐
- Pacemaker/implanted defibrillator ☐
- Rheumatic heart disease ☐
- Stroke ☐
- Other________________

Respiratory Health
- Aspiration ☐
- Asthma ☐
- Bronchitis ☐
- COPD ☐
- Emphysema ☐
- Pneumonia ☐
- Seasonal allergies ☐
- Shortness of breath ☐
- Sinus troubles ☐
- Other________________

Endocrine Health
- Diabetes, type 1 (childhood onset) ☐
- Diabetes, type 2 (adult onset) ☐
- Hyperthyroid ☐
- Hypothyroid ☐
- Other________________

Gastrointestinal Health
- Celiac disease ☐
- Chrohn's disease ☐
- Colitis ☐
- Frequent vomiting ☐
- Heartburn/reflux disorder ☐
- Irritable bowel syndrome ☐
- Malnutrition ☐
- Stomach ulcer ☐
- Other________________

Neurological and Mental Health
- Alcohol/drug addiction ☐
- Anxiety ☐
- Attention deficit hyperactivity disorder ☐
- Autism ☐
- Bipolar disorder ☐
- Cerebral palsy ☐
- Depression ☐
- Eating disorder ☐
- Epilepsy ☐
- Intellectual or developmental disabilities ☐
- Migraines ☐
- Obsessive-compulsive disorder ☐
- Post-traumatic stress disorder ☐
- Schizophrenia ☐
- Seizures ☐
- Traumatic brain injury ☐
- Trisomy 21 (Down Syndrome) ☐
- Other________________

Musculoskeletal Health
- Artificial joint ☐
- Ehlers-Danlos syndrome ☐
- Fractures ☐
- Osteoporosis/Osteopenia ☐
- Other________________

Infectious Disease
- Chicken pox ☐
- Hepatitis ☐
- HIV or AIDS ☐
- MRSA ☐
- Oral herpes (cold sores) ☐
- Sexually transmitted infection ☐
- Shingles ☐
- Tuberculosis ☐
- Other________________

Cancer
- Cancer or tumor diagnosis ☐
  - Chemotherapy ☐
  - Radiation therapy ☐
  - Surgery ☐
- Other________________

Other Health Problems
- Chronic pain ☐
- Do you have a pain contract? ☐
- Fainting or dizzy spells ☐
- Glaucoma ☐
- Kidney disease ☐
- Liver disease ☐
- Lupus ☐
- Other________________

MEDICAL HISTORY SPECIFICS - Continued

Do you have any disease, condition, or problem that's not listed on the previous page? If so, please explain:

____

____

____

____

MEDICATION: Please list (or show us your own printed record) all prescriptions and non-prescription medications. This includes vitamins, herbs, supplements, home remedies, birth control pills, inhalers, over the counter pain pills (Advil, Aleve, Tylenol, etc).

☐ Check box if you do not take any prescription or over the counter medications.
☐ Check box if you brought a list of your medications.

Medication	Dose (e.g. mg/pill)	Times per day?

ALLERGY OR INTOLERANCE: Please list any allergies or intolerances (and the reaction) below. **No known allergies** ☐

Allergy or Intolerance	Reaction (describe)

If you are completing this form for another person, what is your name and relationship to that person?

Name: ______________________________ Relationship: ______________________________

If executing this form as the patient's personal representative, I represent and warrant that I have full legal right and authority to consent to the performance of any procedure(s) on this patient. If for any reason I no longer have such legal right and authority, I will immediately notify the practice in writing.

Note: It is important for both the doctor and patient to talk honestly about the patient's health before dental treatment starts.

I have answered the above questions completely, accurately and to the best of my ability.

Signature of Patient/Legal Guardian: ______________________________ Date: ______________