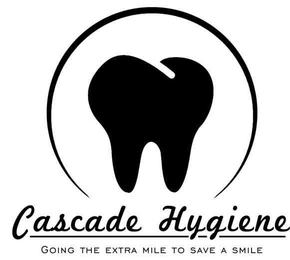

Medical Dental History

Patient Name ______________________ Date of Birth ____________

Please list all medications being taken: ______________________

____

____

____

Preferred Pharmacy ______________________ Phone ____________

Physician ______________________ Phone ____________ Fax ____________

Street ______________________ City ____________ State ______ Zip ______

Dentist ______________________ Phone ____________ Fax ____________

Street ______________________ City ____________ State ______ Zip ______

Medical Dental History

1. Has an antibiotic pre-medication been needed for dental treatment in the past? ☐ YES ☐ NO ☐ UNSURE
2. Reason for today's visit: ______________________
3. Date of last dental care: ______________________
4. Please check (☑) if you experience problems with any of the following:

☐ BAD BREATH OR TASTE
☐ DRY MOUTH
☐ FOOD COLLECTION IN TEETH
☐ YOUR PARTIALS OR DENTURES
☐ SENSITIVITY TO SWEETS
☐ MOUTH SORENESS / GROWTHS
☐ SENSITIVITY TO HOT
☐ SENSITIVITY TO COLD
☐ OTHER ____________

5. Please describe any medical condition(s) or long-term disabilities: ______________________

____

6. Please check (☑) if you have any of the following:

☐ **ALZHEIMER'S**
☐ ANEMIA
☐ ARTHRITIS, RHEUMATISM
☐ ARTIFICIAL HEART VALVE
☐ ARTIFICIAL JOINTS
☐ ASHTMA
☐ BACK PROBLEMS
☐ **BLIND**
☐ BLOOD DISEASE
☐ CANCER
☐ **CEREBRAL PALSEY**
☐ CHEMICAL DEPENDENCY
☐ CHEMOTHERAPY
☐ CIRCULATORY PROBLEMS
☐ CORTISONE TREATMENTS
☐ COUGH UP BLOOD
☐ PERSISTENT COUGH
☐ **DEAF**
☐ **DEMENTIA**
☐ DIABETES
☐ **DISABLED**
☐ EPILEPSY / SEIZURES
☐ FAINTING
☐ GLAUCOMA
☐ HEADACHES
☐ HEART MURMUR
☐ HEART PROBLEMS
☐ HEMOPHILIA
☐ HEPATITIS
☐ HIGH BLOOD PRESSURE
☐ HIV / AIDS
☐ JAW PAIN
☐ KIDNEY DISEASE
☐ LIVER DISEASE
☐ MITRAL VALVE PROLAPSE
☐ **MULTIPLE SCLEROSIS**
☐ PACEMAKER
☐ **PARKINSON'S**
☐ RADIATION TREATMENT
☐ RESPIRATORY DISEASE
☐ RHEUMATIC FEVER
☐ SCARLET FEVER
☐ SHORTNESS OF BREATH
☐ SKIN RASH
☐ STROKE
☐ SWELLING OF FEET
☐ SWELLING OF ANKLES
☐ THYROID PROBLEMS
☐ TOBACCO HABIT
☐ TONSILLITIS
☐ TUBERCULOSIS
☐ ULCER
☐ VENEREAL DISEASE

7. Please check (☑) if you have **ALLERGIES** to any of the following:

☐ ASPRIN
☐ PENICILLIN
☐ LATEX
☐ SULFA
☐ LOCAL ANESTHETIC
☐ CODEINE
☐ OTHER ____________

The above information is accurate and complete to the best of my knowledge. I will not hold Erin Pocius RHD and Cascade Hygiene or any member of the staff responsible for any errors or omissions in the completion of this form.

Signature ______________________ **Date** ____________

Please return this form to: cascadehygiene@gmail.com

Cascade Hygiene provides mobile dental care to people who are unable to travel to the dental office.
cascadehygiene.com | (360) 362-0151 | PO BOX 5842 Bremerton, WA 98312