LARAMIE RIVER Dental

Medical History

General Questions

Primary Physician's Name _____ **Practice Name** _____

Date of Last Physical _____ Please list current medications below:

Medication Name _____ **Dosage** _____ **Reason for Taking** _____

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Medication Name _____ **Dosage** _____ **Reason for Taking** _____

If you need to list more, please write them on the back of this sheet of paper and indicate it by **Circling Here.**

Do you have any allergies? If yes, please list and describe the reaction that occurred _____

_____

Has there been any changes in your health history over the last year? If yes, please explain _____

For Yes/No questions, please circle yes or no.

Head and Neck

Have you ever had a serious injury to the head or neck area? **Yes / No**

If Yes, please explain _____

Have you had any surgeries to the head or neck area? **Yes / No**

If Yes, please explain _____

Cardiovascular

Do you have a prosthetic cardiac valve?	**Yes / No**	Do you have a congenital heart disease?	**Yes / No**
Do you have a history of infective endocarditis?	**Yes / No**	Do you have a pacemaker?	**Yes / No**
Do you have a history of cardiovascular disease?	**Yes / No**	Do you have high blood pressure?	**Yes / No**
Have you ever had abnormal bleeding after surgery?	**Yes / No**	Do you bruise easily?	**Yes / No**
Have you ever been diagnosed with a bleeding disorder?			**Yes / No**
Has it been recommended that you take an antibiotic premedication prior to dental procedures?			**Yes / No**

Any other heart conditions we should be aware of: _____

If you are under the care of a cardiologist, please provide their name and contact information:

_____

Blood Born Diseases

Have you ever been diagnosed with HIV? **Yes / No**

Have you ever been diagnosed with Hepatitis? **Yes / No**

If Yes, please circle if it was Hep A, Hep B, Hep C, or Hep D

Diabetes

Have you been diagnosed as prediabetic? **Yes / No**

Are you diabetic? **Yes / No**

If Yes, Type 1 or Type 2? _____

If Yes, what was your last A1C_____ **Date it was last taken:** _____

Skeletal

Have you ever had a spine or neck injury? **Yes / No** Do you have osteoarthritis? **Yes / No**
Do you have multiple sclerosis? **Yes / No**
Have you had a joint replacement? **Yes / No**
If Yes, what joint/joints?_____ When was the surgery done?_____
If Yes, did your orthopedic surgeon prescribe you an antibiotic premedication prior to dental procedures? Yes/No
If Yes, please provide the contact information for your orthopedic surgeon: _____
Any other bone disorder we should be aware of: _____

Bisphosphonate Use

Bisphosphonates are often prescribed for treatment of bone conditions like osteoporosis.
Bisphosphonates are occasionally prescribed as an addition to certain kinds chemotherapy treatment.

Have you ever taken a bisphosphonate (examples: Fosamax, Boniva, Zometa, Reclast, Actonel, Altevia)? **Yes / No**
If Yes, how long have you/were you on the bisphosphonate? _____
If you have discontinued use, when was your last dose? _____

Cancer

Have you ever been diagnosed with cancer? **Yes / No**
If Yes, What kind of cancer? _____ When was the diagnosis?_____
If Yes, Did you have chemotherapy and or radiation as part of the cancer treatment? _____
If Yes, When was your last treatment? _____

Breathing/Lungs

Have you ever had tuberculosis? **Yes / No** Have you ever been told that you snore? **Yes / No**
Do you have asthma? **Yes / No**
If Yes, do you currently use an inhaler? _____
Have you ever been diagnosed with sleep apnea? **Yes / No**
If Yes, Do you use oxygen, CPAP or other breathing device at night? _____
Any other breathing concerns we should be aware of: _____

Gastroenterology

Do you have gastric reflux? **Yes / No** Do you have liver disease? **Yes / No**
Do you have kidney disease? **Yes / No** Are you undergoing dialysis? **Yes / No**
Have you had a organ transplant? **Yes / No** Are you immune compromised? **Yes / No**
Do you have Crohn's disease or inflammatory bowel disease? **Yes / No**

Nervous System and Mental Heath

Have you ever been diagnosed with depression? **Yes / No** Do you have memory loss? **Yes / No**
Have you been diagnosed with a learning disability? **Yes / No** Do you have epilepsy or seizures? **Yes / No**
Do you have reduced fine motor function (i.e. holding or using a toothbrush)? **Yes / No**
Have you been diagnosed with a nervous system disorder? **Yes / No**
If Yes, Please describe. _____
Any other Nervous System of Mental Health concerns we should be aware of: _____

Substance Use

Have you ever smoked cigarettes? **Yes / No**
If Yes, how many per day and for how long? _____
Have you ever used smokeless tobacco? **Yes / No** Do you smoke a pipe? **Yes / No**
Do you use an E-vape? **Yes / No** Do you smoke marijuana? **Yes / No**
Do you have a history of substance abuse? **Yes / No**
If Yes, please list: _____

For Women

Are you pregnant? **Yes / No** Are you breastfeeding? **Yes / No**
If Yes, how many weeks?_____