St. Luke's Dental Health Center Medical/Dental History

Patient Name: _____ Date of Birth: _____

Sex: ☐ Male ☐ Female ☐ Other_____

Gender Identity: ☐ Male ☐ Female ☐ Other_____

Medical History

Primary Care Provider: _____ **Date of last physical exam:** _____

Specialists (specialty, provider name/phone number, reason)

Specialty	Provider Name/Phone Number	Reason

Surgical History (surgery, date)

❑ Heart surgery (surgery type, date, list cardiologist in specialty section) _____

_____

❑ Total Joint Replacement (Joint, Date, list orthopedic provider in specialty section) _____

_____

❑ Dental surgery (dates) _____

Surgery	Date	Surgery	Date

Hospitalizations

Hospitalization	Date	Hospitalization	Date

Has the patient ever had any of the following? (Mark X and explain)

X	Problem	If yes, please explain (diagnosis, dates, management)	Additional Requests
	Heart Murmur/Problems	Diagnosis: _____ Cardiologist: add to specialist section above Last visit/frequency of follow-up: _____ _____ Planned surgery (past surgeries add to surgical hx): _____ _____ Blood thinners: no yes --Add medications to medication list Functional limitations: _____ SBE prophylaxis status (we can obtain): no yes	Bleeding labs if on blood thinners other than aspirin
	High Blood Pressure	Typical BP: _____/_____mmHg	
	Stroke	Explain:	
	Epilepsy/Seizures	Type of Seizures: What does seizure look like? _____ _____ Date of last seizure: _____ Hospitalizations: no yes (if yes, add to hospitalizations section) Management of Seizure: _____ _____ Emergency medication/instructions for administration: _____ _____	Please be sure to bring any emergency seizure medications to each dental appointment
	Psychiatric Care	Explain:	
	Intellectual Disability	Explain:	
	Autism	Recommended Accommodations:	
	ADHD		
	Asthma	Severity: _____ Triggers: _____ Date of last attack: _____ Hospitalizations: no yes (if yes, add to hospitalizations section) Does asthma resolve easily with inhaler? no yes Spacer or nebulizer needed? no yes	Please bring any inhalers/ spacers needed to all dental appointments
	Tuberculosis	Explain:	
	Diabetes	Type: I II Last HbA1C date and value: _____ Frequency of measuring blood glucose: _____ Last blood sugar measurement date/time and value (preferably right before dental appointment): _____ _ Hospitalizations: no yes (if yes, add to hospitalizations section)	Attach copy of labs or write in values to the left
	Kidney Problems	Explain:	
	Hepatitis/Liver Disease	Explain:	
	Bleeding Problems	Diagnosis: _____ If medication induced, what is medication? _____ Hematologist: please add to specialist section Management: _____	Bleeding labs

	Anemia	Explain:	
	Cancer or Radiation Treatment	Type of Cancer: Remission: no yes Currently undergoing therapy: no yes Radiation: no yes Location: _____ Please add hospitalizations/surgeries above. Please add chemotherapies to medication list.	CBC with differential if undergoing cancer therapy
	Organ/Bone Marrow Transplant	Explain:	
	HIV/AIDs	Explain:	
	Hearing Problems	Explain:	
	Vision Problems	Explain:	
	Tobacco/ Drug/ Alcohol Use	Explain:	

Does the patient have other conditions not listed? No Yes

Condition	**Explain (diagnosis, dates, management)**

Is the patient allergic to any medications, foods, latex, or other things? No Yes Don't Know

Allergen	**Reaction**	**Allergen**	**Reaction**

Does patient take any medications? No Yes (please attach list—medication, indication, dosage)

Has patient ever used drugs to treat bone problems (eg. Zometa, Aredia, Xgeva)? No Yes _____

Dental History (new patients only)

Has the patient ever been to a dentist? No Yes

Name of previous dentist: _____ Date of last dental visit: _____

Does the patient have a toothache, sore or swelling in the mouth? No Yes _____

Has a doctor ever recommended antibiotics before dental treatment? No Yes Why? _____

Trauma to mouth or teeth? No Yes

_____ Oral Habits? No Yes

I agree this information is accurate to the best of my knowledge.

Signature of Parent/Guardian/Agency Staff_____ Date_____

Additional Notes: