Mukilteo Dental Center

Print Form

Patient's Name _____ BIRTHDATE _____ TODAY'S DATE _____

DENTAL HISTORY

Reason(s) for this dental appointment: ☐ Examination ☐ Emergency ☐ Consultation

Do you have a specific dental problem? Describe. _____

Do you smoke or chew tobacco? ☐ Yes ☐ No

Any sores or growths in your mouth? Discuss: _____

Do you wear a nightguard? ☐ Yes ☐ No Do you brux, grind, or have discomfort in the jaw area? _____

Date of last dental visit: _____ Date of last full mouth x-rays (16 small films or panoramic): _____

Previous Dentist: _____ Phone Number: _____

MEDICAL HISTORY

Are you in overall good health? ☐ Yes ☐ No

Physician's Name: _____ Phone Number: _____

Current Medical Conditions: _____

List of Major Operations or Hospitalizations: _____

LIST OF MEDICATIONS THAT YOU ARE TAKING: _____

ALLERGIES OR ADVERSE REACTIONS TO MEDICATIONS

	Y	N		Y	N		Y	N
Local anesthetic	☐	☒	Latex	☐	☒	Other Antibiotics	☐	☒
Codeine or other narcotic	☐	☒	Barbiturates, sedatives, sleeping pills	☒	☐	Reaction to Metals	☐	☒
Sulfa Drugs	☐	☒	Penicillin	☐	☒	Other?	☐	☒

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS?

	Y	N		Y	N		Y	N
High Blood Pressure	☒	☐	Hepatitis B or C	☐	☒	Arthritis	☐	☒
Heart Attack/Heart Disease	☐	☒	Ulcers/Acid Reflux	☐	☒	Asthma	☐	☒
Heart Murmer	☒	☐	Diabetes - Type? ____	☐	☒	Allergies	☐	☒
Rheumatic/Scarlet Fever	☒	☐	Psychiatric Care	☐	☒	Respiratory Disease	☐	☒
Stroke	☒	☐	Anemia/Excessive Bleeding	☐	☒	Tuberculosis	☐	☒
Pacemaker	☐	☒	Cancer	☐	☒	Venereal Disease	☐	☒
Artificial Joint (hip, knee)	☐	☒	Radiation Treatment	☐	☒	AIDS/HIV Positive	☐	☒
Hepatitis A (Infectious)	☐	☒	Epilepsy or Seizures	☐	☒	Vincent's Dx/Trenchmouth	☐	☒

Are you currently pregnant? ☐ ☒ If yes, expected delivery date? _____

	Y	N
Do you have a medical condition that requires antibiotic treatment before dental therapy?	☐	☒

MEDICAL UPDATES & NOTES

Date	Note	Date	Note