Whiteside County Community Health Clinic

Dental Medical History

Patient Sticker

Previous Dentist:_____

Approximate Last Dental Visit:_____

Medical Information

Please mark all that apply

Physician Name:_____

Physician Phone:_____

- ☐ Currently receiving medical treatment
  Explain_____
- ☐ Have had a serious illness, operation, or been hospitalized in the last 5 years
  Explain_____

FEMALES ONLY

- ☐ Pregnant
  Estimated Due Date
  _____
- ☐ Nursing
- ☐ Taking Birth Control

Please mark if you use any of the following:

- ☐ Tobacco
  - ☐ Cigarette/cigar/pipe
    Packs/day:_____
    Years of being a smoker:_____
  - ☐ Smokeless (e.g. chew, snuff, etc.)
- ☐ Vape
- ☐ Alcohol
  Drinks/week:_____
- ☐ Marijuana*
- ☐ Cocaine*
- ☐ Heroin*
- ☐ Methamphetamine*
- ☐ Ecstasy*
- ☐ Other illicit drugs*:_____

*Time since last use:_____

- ☐ Have had an orthopedic **total joint replacement** (hip, knee, shoulder, etc)
  - ☐ Date(s):_____
  - ☐ Hospital/Location:_____
  - ☐ Any complications:_____
- ☐ Currently taking, previously taken, or scheduled to begin taking medications for **osteoporosis**: alendronate (Fosamax) or risedronate (Actonel)?
- ☐ Currently taking or scheduled to begin treatment with **IV bisphosphonates** (Aredia or Zemeta) for bone pain, hypercalcemia, multiple myeloma or metastatic cancer?
  Date treatment began:_____
- ☐ Currently taking **blood thinners** (Coumadin/Warfarin, Plavix, Brilinta, Xarelto, Eliquis, Pradaxa, etc)
- ☐ **Heart condition(s)**
  - ☐ Artificial valve
  - ☐ Previous infective endocarditis
  - ☐ Heart transplant
  - ☐ Congenital Heart Disease (CHD)
    - ☐ Unrepaired, cyanotic CHC
    - ☐ Repaired (completely) in last 6 months
    - ☐ Repaired CHD with Residual defects

Allergies

Please list all allergies and type of reaction you have

Continue on other side of page

Whiteside County Community Health Clinic

Dental Medical History

Medical Conditions *Please mark all that apply*	
☐ Anxiety ☐ Depression ☐ ADHD ☐ Bipolar Disorder ☐ Schizophrenia ☐ Developmental Disability ☐ Autism Spectrum Disorder ☐ Blindness ☐ Cerebral Palsy ☐ Deafness ☐ Intellectual Disability ☐ Diabetes ☐ Type I ☐ Type II ☐ GERD/Acid Reflux ☐ Stomach/Intestinal Disorder:_____ ☐ Eating Disorder:_____ ☐ Hepatitis – Type:_____ ☐ Other Liver Disease:_____ ☐ Kidney Disease:_____ ☐ Thyroid Disease:_____ ☐ Cancer:_____ ☐ Radiation Therapy (Head/Neck)	☐ Epilepsy/Seizure Disorder ☐ High Blood Pressure ☐ Stroke Date:_____ ☐ High Cholesterol ☐ Heart Ailment:_____ ☐ Heart Murmur ☐ Chest Pain ☐ Pacemaker ☐ Rheumatic Fever ☐ Bleeding/Clotting Disorder:_____ ☐ HIV/AIDS ☐ Sexually Transmitted Infection:_____ ☐ Shortness of Breath ☐ Asthma ☐ COPD/Emphysema ☐ Tuberculosis ☐ Glaucoma ☐ Arthritis ☐ Osteoporosis ☐ Artificial Joint Replacement ☐ Plates/Rods/Screws ☐ Other:_____
Medications *Please list all medications you are currently taking*	

If there is any reason we cannot perform we cannot perform x-rays, please let us know. As a public health dental clinic, we do not perform all dental procedures and we may need to refer you to a specialist.

I hereby consent to dental procedures performed by the Whiteside County Community Health Clinic. I declare that all information is accurate.

Signature: _____ Date:_____