Mālama I Ke Ola Dental Medical History Form

Last Name: _____ **First Name:** _____

DOB: _____ **Height:** _____ **Weight (lbs.):** _____

If you are completing this form for another person, what is your relationship to that person?

Your Name: _____ Relationship to Patient: _____

Do you have any of the following diseases or problems?

- Active Tuberculosis ..... ❑Yes ❑No ❑DK
- Persistent cough longer than 3 weeks ..... ❑Yes ❑No ❑DK
- Cough that produces blood ..... ❑Yes ❑No ❑DK

If yes, please **STOP** and notify the receptionist.

- Do you currently have any dental pain or discomfort? ❑Yes ❑No ❑DK

If yes, please describe:

_____

_____

- Do you have any other problems in your mouth? ❑Yes ❑No ❑DK

If yes, please describe:

_____

_____

- Have you had any problems with previous dental treatment? ❑Yes ❑No ❑DK

If yes, please describe:

_____

_____

- Do you have TMD, grind teeth, have clicking, popping, or discomfort in the jaw? ❑Yes ❑No ❑DK

If yes, please describe:

_____

_____

Mālama I Ke Ola Dental Medical History Form

Medical Information

Are you currently under the care of a physician? …….. ❑Yes ❑No

Physician's Name: _____ Phone Number: _____

- **Joint Replacement:**

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ❑Yes ❑No ❑DK

Date of joint replacement: _____ If yes, have you had any complications?

_____

- **Endocarditis:**

Have you had or currently have any of the following below:
Problems with a heart valve …….. ❑Yes ❑No ❑DK
Artificial (prosthetic heart valve) …….. ❑Yes ❑No ❑DK
REPAIRED congenital heart disease …….. ❑Yes ❑No ❑DK
UNREPAIRED congenital heart disease …….. ❑Yes ❑No ❑DK
Previous Endocarditis …….. ❑Yes ❑No ❑DK

If yes, please describe:

_____

_____

Do you require antibiotic prophylaxis before dental procedure? …… ❑Yes ❑No ❑DK

- **Bisphosphonates:**

Are you taking, have taken or scheduled to begin taking any ORAL bisphosphonates?
Examples include ***Alendronate (Fosamax)*** or ***Risedronate (Actonel)***

❑Yes ❑No ❑DK

Since 2001, were you treated or are you scheduled to begin treatment with ***INTRAVENOUS*** bisphosphonates? Examples include ***Aredia*** and ***Zometa.***

❑Yes ❑No ❑DK

<u>For Women Only:</u>

Are you pregnant? …….. ❑Yes ❑No ❑DK
Number of weeks: _____
Taking birth control/hormonal replacements …….. ❑Yes ❑No ❑DK
Nursing …….. ❑Yes ❑No ❑DK

Mālama I Ke Ola Dental Medical History Form

Are you allergic to or have you had a reaction to:

Local Anesthetics ..... ❑Yes ❑No ❑DK
Aspirin ..... ❑Yes ❑No ❑DK
Penicillin or other antibiotics ..... ❑Yes ❑No ❑DK
Barbiturates, sedatives, or sleeping pills ..... ❑Yes ❑No ❑DK
Sulfa Drugs ..... ❑Yes ❑No ❑DK
Codeine or other narcotics ..... ❑Yes ❑No ❑DK
Metals ..... ❑Yes ❑No ❑DK
Latex (rubber) ..... ❑Yes ❑No ❑DK
Iodine ..... ❑Yes ❑No ❑DK
Food ..... ❑Yes ❑No ❑DK

Other allergies: _____

- **Heart/Blood**

Chest pain ..... ❑Yes ❑No ❑DK
Congestive heart failure ..... ❑Yes ❑No ❑DK
Pacemaker ..... ❑Yes ❑No ❑DK
Heart attack ..... ❑Yes ❑No ❑DK
High blood pressure ..... ❑Yes ❑No ❑DK
Low blood pressure ..... ❑Yes ❑No ❑DK
Heart murmur ..... ❑Yes ❑No ❑DK
Bleeding problems ..... ❑Yes ❑No ❑DK
Stroke ..... ❑Yes ❑No ❑DK
Rheumatic Fever ..... ❑Yes ❑No ❑DK
Rheumatic heart disease ..... ❑Yes ❑No ❑DK

- **Cancer**

Cancer ..... ❑Yes ❑No ❑DK
Radiation Treatment ..... ❑Yes ❑No ❑DK
Chemotherapy ..... ❑Yes ❑No ❑DK

- **Lungs**

Asthma ..... ❑Yes ❑No ❑DK
Chronic Obstructive Pulmonary Disease (COPD) ..... ❑Yes ❑No ❑DK

- **Hormone**

Diabetes Type I or II ..... ❑Yes ❑No ❑DK
Thyroid problems ..... ❑Yes ❑No ❑DK

- **Kidney**

Kidney Dialysis ..... ❑Yes ❑No ❑DK
Kidney Failure ..... ❑Yes ❑No ❑DK

- **Liver**

Hepatitis C ..... ❑Yes ❑No ❑DK

Other liver diseases: _____

- **Nerve**

Epilepsy ..... ❑Yes ❑No ❑DK
Chronic pain ..... ❑Yes ❑No ❑DK
Neuropathy ..... ❑Yes ❑No ❑DK

Mālama I Ke Ola Dental Medical History Form

- **Gastrointestinal (GI)**

Gastroesophageal reflux (GERD) ..... ❑Yes ❑No ❑DK
GI ulcers ..... ❑Yes ❑No ❑DK
Eating Disorder ..... ❑Yes ❑No ❑DK

- **Bone/Joint**

Arthritis ..... ❑Yes ❑No ❑DK
Osteoporosis ..... ❑Yes ❑No ❑DK

- **Immune**

Autoimmune disease ..... ❑Yes ❑No ❑DK
AIDS or HIV ..... ❑Yes ❑No ❑DK
Recurrent infections ..... ❑Yes ❑No ❑DK

Please describe: _____

- **Head/Ears/Eyes/Nose/Throat**

Severe headaches/Migraines ..... ❑Yes ❑No ❑DK
Hearing problems ..... ❑Yes ❑No ❑DK
Neurological disorder ..... ❑Yes ❑No ❑DK
Fainting spells or seizures ..... ❑Yes ❑No ❑DK
Sinus problems ..... ❑Yes ❑No ❑DK
Vision problems ..... ❑Yes ❑No ❑DK

- **Mental Health**

Mood disorder ..... ❑Yes ❑No ❑DK
Substance use disorder ..... ❑Yes ❑No ❑DK
Other psychiatric disorder ..... ❑Yes ❑No ❑DK
Sleep disorder ..... ❑Yes ❑No ❑DK

Please list any diseases, conditions, or problems not listed above:

_____

_____

Please list **ALL** prescriptions, over the counter medications and supplements you are taking:

_____

_____

Print Name if Signing for Patient: _____

Signature: _____

Date: _____