Reflections Dental Centre
2600 SW Barton Street, #E20, Seattle, WA 98126
(206) 923-3684

CHART NUMBER

Medical History

Certain illnesses and medications may make it necessary for us to alter your dental treatment. In our endeavor to provide you with the most appropriate health care, it is necessary to collect the following information about your health. Please indicate by checking yes or no for all descriptions that are part of your medical profile. Please be assured that this document will be treated with the utmost confidentiality.

Patient name:

Conditions			Premedication Required by MD		
Abdominal Bleeding	☐ Yes	☐ No	Respiratory Problems	☐ Yes	☐ No
Allergy Problems	☐ Yes	☐ No	Radiation Therapy	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	Sinus Problems	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Skin Rashes	☐ Yes	☐ No
Back or Neck Pain	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Blood Pressure Problems	☐ Yes	☐ No	Taken Fen-Phen	☐ Yes	☐ No
Blood Disorders	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Bone or Joint Problems	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No	**For Women**		
Cancer / Tumor	☐ Yes	☐ No	Are you using birth control pills?	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No	Are you pregnant?	☐ Yes	☐ No
Cosmetic Surgery	☐ Yes	☐ No	Are you nursing?	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	**Medication Allergies**		
Emphysema	☐ Yes	☐ No	Aspirin	☐ Yes	☐ No
Epilepsy or Seizures	☐ Yes	☐ No	Codeine	☐ Yes	☐ No
Fainting Spells	☐ Yes	☐ No	Dental Anesthetics	☐ Yes	☐ No
Fever Blisters	☐ Yes	☐ No	Erythromycin	☐ Yes	☐ No
Frequent Nosebleeds	☐ Yes	☐ No	Penicillin	☐ Yes	☐ No
Frequent or Severe Headaches	☐ Yes	☐ No	Sulfa	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Tetracycline	☐ Yes	☐ No
HIV-Positive / AIDS	☐ Yes	☐ No	**Other Allergies**		
Hay Fever	☐ Yes	☐ No	Jewelry	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Metals	☐ Yes	☐ No
Heart Problems	☐ Yes	☐ No	Latex	☐ Yes	☐ No
Heart Valve Problems	☐ Yes	☐ No	Other (specify on next page):	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No	**Other Information**		
Hepatitis, Jaundice, Liver Problems	☐ Yes	☐ No	Do you use tobacco products?	☐ Yes	☐ No
Herpes or Other STD	☐ Yes	☐ No	Do you drink alcohol?	☐ Yes	☐ No
Joint Replacement	☐ Yes	☐ No	History of alcohol abuse?	☐ Yes	☐ No
Kidney or Bladder Problem	☐ Yes	☐ No	Are you on a special diet?	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No	If so, describe:		

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Primary care physician:

Name | Phone number

Have you ever been hospitalized? ☐ **YES** ☐ **NO**

If you've been hospitalized, please describe when and purpose:

Please list all medications you are taking:

Please list all other allergies not specified on first page:

Dental History:

Are you apprehensive about going to the dentist?	☐ Yes	☐ No
Are you satisfied with color of your teeth?	☐ Yes	☐ No
Do you have any broken or chipped teeth?	☐ Yes	☐ No
Do you have dental pain?	☐ Yes	☐ No
Are your teeth crowded?	☐ Yes	☐ No
How often do you brush?		
How often do you floss?		

Additional information you would like us to know:

Signed: _____ Date signed: _____

Patient signature

Signed: _____ Date signed: _____

Doctor signature