



**WEST SALEM CLINIC – DENTAL**

**HEALTH HISTORY**

Patient Chart Identification
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1. Describe your dental problem: \_\_\_\_\_

2. What type of dental treatment do you feel you need? \_\_\_\_\_

3. When was your last dental treatment/check up?  
\_\_\_\_\_

4. When was your last dental cleaning? \_\_\_\_\_

**The following information is necessary for you to receive dental treatment and will be completely confidential. Dental treatment will not be refused because of existing medical conditions.**

Please indicate your answers to the following questions.

1. What is the name of your primary care provider? \_\_\_\_\_

Date of last physical exam? \_\_\_\_\_

Provider phone number? \_\_\_\_\_

**Yes / No**

2. Have you had a recent illness? Please explain: _____																				
3. Are you undergoing any medical/health treatment at this time? Please explain: _____																				
4. Have you been hospitalized in the past two years? Please explain: _____																				
5. Have you had any unfavorable reaction or known allergy to penicillin, or any drugs or medications? _____																				
6. Have you ever had any excessive bleeding requiring treatment or do you bleed for a long time when you are cut?																				
7. Are you currently taking any kind of medicine or drugs (prescription or over the counter)? If yes please list below. <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Drug Name</th> <th style="text-align: left;">Dose/Frequency</th> <th style="text-align: left;">Reason</th> </tr> </thead> <tbody> <tr> <td>1. _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>2. _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>3. _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>4. _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>5. _____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table>	Drug Name	Dose/Frequency	Reason	1. _____	_____	_____	2. _____	_____	_____	3. _____	_____	_____	4. _____	_____	_____	5. _____	_____	_____		
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5. _____	_____	_____																		
8. Have you ever taken drugs without a prescription?																				
9. Have you every been in a drug/alcohol treatment program? If so, when? _____																				
10. Have you ever taken the drug Phen-Fen?																				

