UnityPoint Health
St. Luke's Hospital

St. Luke's Dental Health Center
Medical History

Patient name		Date of birth
Family doctor		Doctor's phone
Date of last physical exam	Height	Weight

Is patient under medical treatment now? ☐ No ☐ Yes, for what?

Has patient ever had surgery? ☐ No ☐ Yes (list all surgeries and dates)

Are patient's immunizations up to date? ☐ No ☐ Yes

Has a doctor ever recommended antibiotics before dental treatment? ☐ No ☐ Yes

Does patient have a developmental disability? ☐ No ☐ Yes (explain)

Does patient smoke or use smokeless tobacco? ☐ No ☐ Yes

Does patient take any medications? ☐ No ☐ Yes (please list)

Is patient allergic to any medications, foods, latex or other things? ☐ No ☐ Yes (please list)

Has the patient ever had any of the following?

Joint Replacement	☐ No ☐ Yes	Hepatitis or Liver Disease	☐ No ☐ Yes	Anemia	☐ No ☐ Yes
Heart Murmur	☐ No ☐ Yes	Cancer or Radiation Treatment	☐ No ☐ Yes	Bleeding Problems	☐ No ☐ Yes
Congenital Heart Problems	☐ No ☐ Yes	Asthma Problems	☐ No ☐ Yes	HIV/AIDS	☐ No ☐ Yes
Artificial Heart Valves	☐ No ☐ Yes	Patient uses an inhaler	☐ No ☐ Yes	Autism	☐ No ☐ Yes
High Blood Pressure	☐ No ☐ Yes	Epilepsy	☐ No ☐ Yes	ADHD or ADD	☐ No ☐ Yes
Stroke	☐ No ☐ Yes	Tuberculosis	☐ No ☐ Yes	Hearing Impaired	☐ No ☐ Yes
History of Substance Abuse	☐ No ☐ Yes	Diabetes	☐ No ☐ Yes	Psychiatric Care	☐ No ☐ Yes
Sexually Transmitted Diseases	☐ No ☐ Yes	Kidney Problems	☐ No ☐ Yes	Female: Are you pregnant?	☐ No ☐ Yes

Other (please list) _____

Is this the patient's first dental visit? ☐ No ☐ Yes

Name of previous dentist	Date of last dental visit

Does the patient have a toothache, sore or swelling in the mouth? ☐ No ☐ Yes

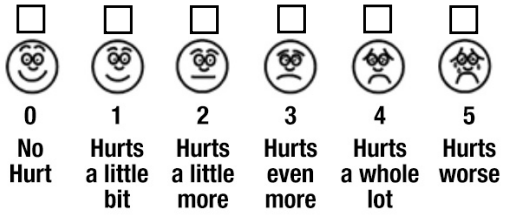
Is the patient in pain? ☐ No ☐ Yes (check pain level on pain rating scale at right)

Location of pain _____

When pain started _____

What helps the pain? _____

What makes the pain worse? _____



I agree this information is accurate to the best of my knowledge.
By typing my name below, I agree I am electronically signing this form.

Signature of Parent/Guardian/Agency Staff	Date

Clear Form