Jason W. Dulac, D.D.S.
6124 Brandon Ave. Springfield, VA 22150
(703) 451-4500 DulacDDS.com

# Health History

If you currently have a primary care physician or doctor, please provide the name and contact information below:

_____

## Premedication with antibiotics prior to dental treatment:

Do you have an artificial heart valve? Yes / No
Did you have a recent joint surgery and the doctor told you that you are required to pre-med with antibiotics before dental treatment? Yes / No
Are you severely ill or immunocompromised such that you may need premedication prior to dental treatment? Yes / No
Did you have an older joint surgery, but the surgeon still wants you to premed? Yes / No

(Pre-medication is required for all artificial heart valves. It is no longer recommended for joint surgeries, but we sometimes encounter doctors who prefer otherwise. The standard is 2g Amoxicillin 1 hour prior, or 600mg Clindamycin (if an allergy to amoxicillin exists). We have it in the office, it's safe to take up to four hours after the procedure, and is fine to take and start the procedure.)

## Allergies:

Do you have allergy to Penicillin or Amoxicillin? Yes / No
Do you have any other medical / dental allergies you're aware of? Yes / No

Known Allergies: _____

## Medical History:

Do you have Diabetes? Yes / No
Do you have hepatitis? Yes / No
Do you have HIV / AIDS? Yes / No
Are you immunocompromised (weak immune system)? Yes / No
Any renal failure or kidney disease? Yes / No
Any liver failure or Liver disease? Yes / No
Any high blood pressure or heart condition? Yes / No
Are you currently being treated for any depression, anxiety, or nerve or neurological condition? Yes / No
Are you currently being treated for asthma or any lung or breathing condition? Yes / No
Are currently being treated for any Autoimmune conditions? Yes / No
Are you currently undergoing cancer treatment (radiation, chemo)? Yes / No

If so, for what type of cancer: _____

_____ _____
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## Tobacco History:

Do you use tobacco (smoking, smokeless, chew, vape, cigars, hookah etc.)? Yes / No
Did you once smoke and quit? Yes / No
If so how many packs/day for how many years? _____

## Current medications:

Please list any medications you're currently taking including pills (or injections):

_____

(You may also provide a medication list if that is preferred.)
If you would rather provide **the address and phone number** of your pharmacy, Dr Dulac can pull in the medications: _____
Are you taking any pain medications currently? Yes / No
If so, what and for what? _____
Have you ever taken a bisphosphonate pill or injection (for bone density)? Yes / No

## Female Patients:

Are you pregnant or trying to become pregnant? Yes / No
Are you currently breastfeeding (or pumping)? Yes / No

## Do you have a history of:

Head or neck injuries? Yes / No
Cancer? Yes / No
If yes, what type and when: _____
Osteoporosis / osteopenia? Yes / No
Pacemaker? Yes / No

Is there any other medical condition you've been diagnosed or are aware of or have a history of not listed on this questionnaire?

_____

## Snoring and Sleep Apnea:

Do you snore? Yes / No
Does your sleeping partner snore? Yes / No
Have you ever taken a sleep study? Yes / No
Have you ever been diagnosed with sleep apnea? Yes / No

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If so what treatment are you currently using (CPAP, inspire, surgery)?

_____

There are dental appliances for snoring and sleep apnea, if you're interested in learning more, let us know.

_____ _____

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# Dental History

When was your last dental exam or cleaning (month/year, if you can recall)? _____

Do you have any immediate concerns or pain you'd like to address?

_____

_____

On a scale from 1-5, 5 being most terrified, are you fearful of dental treatment? _____

(We offer a number of comfort aids: pillows, blankets, weighted blankets (Xray vest), stress balls, ear plugs and noise canceling head phones. We also offer Nitrous Oxide (Laughing Gas). We can also prescribe you Valium or Xanex. If there's anything we can do to make you more comfortable in the office, please let us know!)

Are you interested in improving your smile? Yes / No

Are any teeth currently sensitive to biting, sweets, hot, or cold? Yes / No
Do you avoid or have difficulty chewing or biting foods? Yes / No
Do your gums bleed when brushing or flossing? Yes / No
Have you ever been treated for or been told you have gum disease? Yes / No

Do you have problems with your jaw joint?
(TMD, popping, clicking, deviating from side to side when opening or closing?) Yes / No
Do you wake up with a headache or sore teeth or jaw fatigue? Yes / No
Do you clench your teeth in the daytime or at night? Yes / No
Do you wear a dental appliance at night?
(Either for clenching at night (a night guard), or for sleep apnea, or a retainer?) Yes / No

(If yes to any of the above, we have a full TMJD Screening form)

Does the amount of saliva in your mouth seem too little or do you find yourself with a dry mouth often? Yes / No
Are you prone to canker sores frequently? Yes / No
Are you prone to recurrent oral herpes lesions (cold sores)? Yes / No
Are there any other dental conditions you're aware of or concerned with that were not addressed on this questionnaire? (If so, note below:) Yes / No

_____

_____ _____

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_____

_____ _____

Name Date