THE UNIVERSITY OF WESTERN AUSTRALIA

DENT 3005:Introduction to Pharmacology

Medical and medication history

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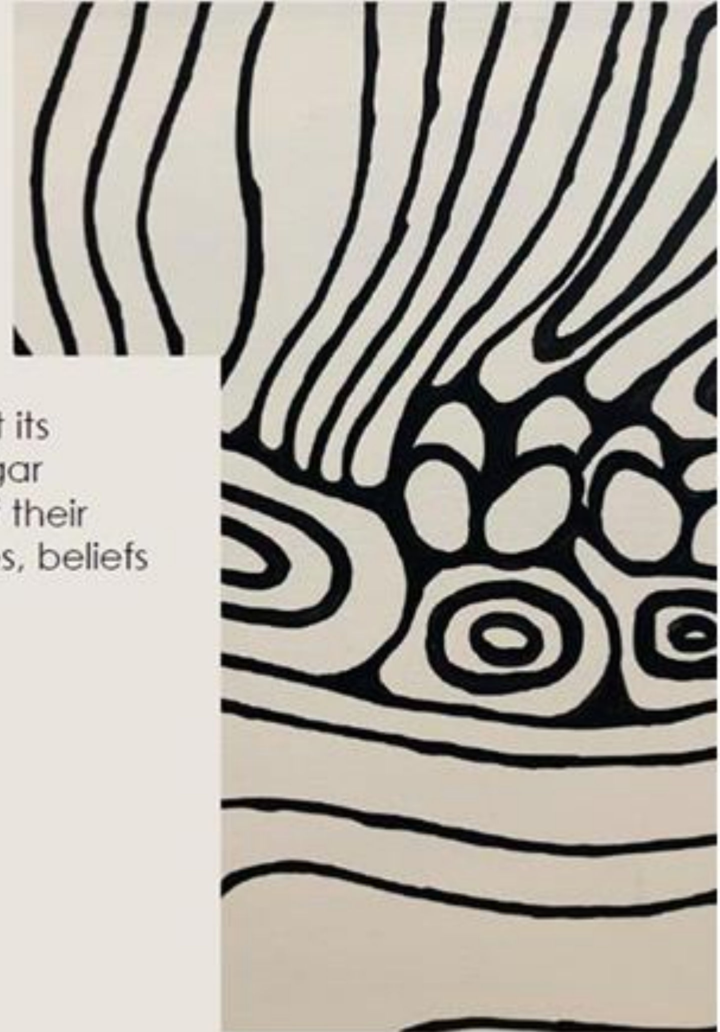
THE UNIVERSITY OF WESTERN AUSTRALIA

Acknowledgement
of country

The University of Western Australia acknowledges that its campus is situated on Noongar land, and that Noongar people remain the spiritual and cultural custodians of their land, and continue to practise their values, languages, beliefs and knowledge.



Artist: Dr Richard Barry Walley OAM

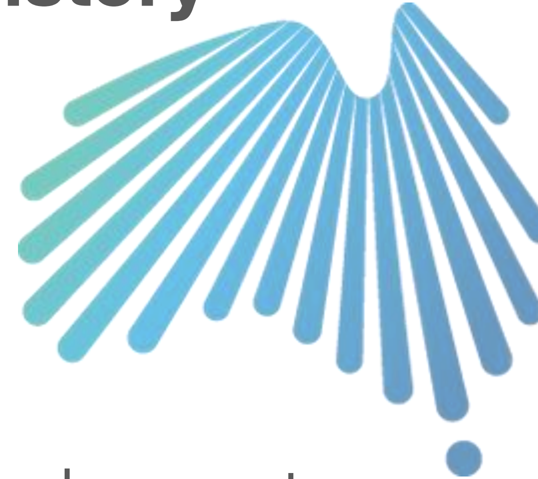
Learning Outcomes

Learning objectives

1. Explain the rationale for each medical history question
2. Identify how systemic diseases and medications impact dental treatment
3. Practice applying this knowledge in clinical setting

Medical History

- **Professional duty**
  - Required by Code of Conduct
  - Foundation for safe, ethical care
- **Accurate records**
  - Factual, up-to-date, legible
  - No biased or judgmental language
  - Include history, diagnosis, treatment, and consent
- **Continuity of care**
  - Clear for other providers
  - Include social, cultural, and psychological factors
- **Confidentiality**
  - Secure storage and access
  - Follow privacy laws
- **Patient rights:** patients can access and request their records



Impressions ☺

- **First impressions matter**
  - Build trust from the start
  - Negative impressions can last
- **Patient anxiety is common**
  - Be calm, friendly, and reassuring
- **Team roles**
  - Dentist: hold the ultimate responsibility
  - Receptionist, dental assistance: aid in building rapport
- **Next steps**
  - What info is needed?
  - How to collect it well?

Open Vs Closed

- **Closed questions**
  - Require brief, definite answers (Yes/No)
  - Useful for medical history
  - E.g., *Do you take medication?*
- **Open questions**
  - Begin with *What, When, Who, Where, Which, or How*
  - Encourage detailed responses and feelings
  - E.g., *What are your main dental concerns?*
- **Use both types**
  - Helps gather complete and relevant info
  - Sets the tone for a positive patient relationship

Personal history – why it matters

- Confirm name, DOB, address, and contact details
- Job roles may affect oral health
  - *Eg. Pastry chef, sommelier…*
  - Stressful jobs → clenching, bruxism
- Occupation may influence treatment planning
  - *Eg. Singers or wind musicians*
- Personal history provides context for tailored care

Medical history – a clinical essential

- Critical for safe and effective treatment
- Prevents avoidable medical complications
- Use clear formats: verbal, written, or electronic
- Ensure patient understands the questions
  - Signature ≠ comprehension
- Verify unclear answers
- Update regularly – health changes over time

Dental history – more than what you see

- Ask about past and recent dental experiences
    - Regular attendance?
    - Recent treatments?
    - Current pain or sensitivity?
    - Bleeding gums?
    - Dental anxieties?
- Patients often recall useful details not visible on exam
- Supports better diagnosis and treatment planning
- Helps build rapport and address patient concerns

System/Category	Medical History Questions
Cardiovascular	Do you have any cardiovascular disease? (e.g. hypertension, heart disease)
Bleeding/Clotting disorders	Do you have a bleeding or clotting disorder? Have you ever had excessive bleeding? Do you have any blood disorders (e.g. anaemia)?
Respiratory	Do you have a respiratory disease? (e.g. asthma, emphysema)
Neurological	Do you have a neurological disorder? (e.g. epilepsy)
Gastrointestinal	Do you have a gastrointestinal disease? (e.g. coeliac disease, inflammatory bowel disease, gastritis)
Endocrine	Do you have an endocrine condition? (e.g. diabetes, thyroid disorder, dyslipidaemia)
Renal/Hepatic	Do you have kidney or liver disease? (e.g. hepatitis)
Bone-modifying agents	Have you ever taken medications such as bisphosphonates or denosumab?
Skin conditions	Do you have any skin diseases?
Psychological health	Do you have any psychological conditions? (e.g. anxiety, depression, dental phobia)
Cancer/Radiation	Do you have a history of cancer? Have you received radiation therapy to the head or neck?
Infectious disease	Have you ever had an infectious disease? (e.g. tuberculosis, hepatitis, HIV)
Hospitalisations	Have you had any past operations or hospitalisations? Were there any complications?
Pregnancy	Are you currently pregnant? If yes, what is your due date?
Allergies	Do you have any allergies to medications, food, or chemicals?
Medications	Are you currently taking any medications, including supplements?
Recreational drug use	Have you ever used recreational drugs?
Smoking/Vaping	Do you currently or previously smoke or vape? Please specify product, quantity (per day/week), and duration
Alcohol use	Do you consume alcohol? Please specify type of drink, amount (per day/week/month/year), and duration

PATIENT PERSONAL & MEDICAL QUESTIONNAIRE

PRIVATE & CONFIDENTIAL

Welcome to our Practice

Please answer these questions as completely as possible.
It will greatly assist us to provide the best dental treatment for you.

PRIVACY STATEMENT: We value your privacy. All of the information which you provide to us will be held and used by us in accordance with our Privacy Policy. A copy of our Privacy Policy is attached to this Questionnaire. Please take the time to read through our Privacy Policy before answering the Questionnaire and speak to one of our staff members if you have any concerns about how we will use your personal information.

Name(Mr/Mrs/Miss/Ms/Dr/Other) ....
(First Names) (Family Name)

Address ....

.... Postcode ....

Date of Birth .... Phone (Home) .... Phone (Work) ....

Phone (Mobile) .... Preferred Daytime Contact: Home / Work / Mobile *(Please Circle)*

E-mail..

Occupation .... Employer ....

Emergency Contact .... Relationship .... Phone ....

Person responsible for payment of accounts ....

Private Health Fund (if applicable) ....

Whom may we thank for recommending you to our practice? ....

The state of your health may have a very significant effect on your dental care.
Please answer these questions fully or discuss them with your dentist:

	Y	N
• I have private and confidential medical matters which I wish to discuss with the dentist	☐	☐
• Are you receiving any medical treatment at present?	☐	☐
• Name of your medical practitioner/specialist		
• Have you ever been in hospital? If yes, nature of hospitalisation and dates:	☐	☐

....

....

• Some medicines may interfere with your dental treatment or react with medicaments used by your dentist. It is important that your dentist knows precisely what medications (if any) that you are taking.

Please list any medications you are currently taking, or have been taking recently *including* injections, herbal remedies, vitamins, supplements, cold/flu treatments, sleeping pills, pain relievers, implants, so we can take appropriate precautions and avoid drug interactions.

Drug Name	Dosage	Duration of Treatment	Purpose/Condition

Please list any known ALLERGIES or ADVERSE REACTIONS to drugs (especially antibiotics eg. penicillin), medicines, antiseptics, local anaesthetics, latex, preservatives that we should know about.

Drug Name	Nature of Reaction	How Long Ago

If you are in any doubt about your medication, please bring a Pharmacy Medication Summary or the bottle or packet(s) to the practice to show the dentist.

..... please turn over →

Please indicate YES or NO if you have ever had any of the following:

	Y	N
Rheumatic fever	☐	☐
Heart condition/cardiac surgery/pacemaker	☐	☐
Heart valve replacement	☐	☐
High or low blood pressure	☐	☐
Blood disorders	☐	☐
Excessive bruising or bleeding	☐	☐
Hepatitis, jaundice or liver disease	☐	☐
Kidney/renal disease	☐	☐
Diabetes	☐	☐
Osteoporosis or low bone density	☐	☐
Rheumatoid arthritis/Lupus (SLE)/Polymyalgia	☐	☐
Joint replacement surgery	☐	☐
Jaw, neck or shoulder injury or pain	☐	☐
Epilepsy/Seizures	☐	☐
Thyroid disease (including goitre)	☐	☐
Tuberculosis (TB)	☐	☐
Asthma/Bronchitis/lung conditions	☐	☐
Nervous system disorder	☐	☐
Anxiety/Depression	☐	☐
Gastroesophageal reflux disease (GORD)	☐	☐
Cancer or malignancy of any kind	☐	☐
Chemotherapy/Radiation therapy	☐	☐
Transplanted organ/bone marrow/stem cells	☐	☐
Snoring/Sleep Apnoea	☐	☐

Have you ever smoked? Y ☐ N ☐ Approx date if quit ...... /...... /...... Do you currently smoke or vape? Y ☐ N ☐

If yes, for how long? .... How much do you smoke .... per day

Have you ever used illicit substances and/or recreational drugs? Y ☐ N ☐ If yes, when? Recent ☐ More than 1 yr ago ☐

Do you consume alcohol? Y ☐ N ☐

Do you suffer from any illness not listed above or carry any infectious disease? Y ☐ N ☐

If yes, please provide details ....

....

***Females*:** Are you pregnant or is there a chance you could be pregnant? Y ☐ N ☐ If yes, date due ....

Are you currently breastfeeding? Y ☐ N ☐

DECLARATION:

In signing this form I acknowledge that this represents an accurate medical history.
I will advise my dentist of any changes to my medical history in the future.
I understand that all medical details will be treated with complete professional confidentiality.
I have read the privacy document provided by this practice.

Patient Signature .... Date ....
(Parent or guardian if under 18 years)

Dentist Signature .... Date ....

Practice Use Only: Review of Information

Patient Signature: .... Date: ...... /...... /......

Dentist Comment: ....

.... Signature .... Date: ...... /...... /......

Patient Signature: .... Date: ...... /...... /......

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Heart condition/cardiac surgery/pacemaker	☐	☐	Epilepsy/Seizures	☐	☐
Heart valve replacement	☐	☐	Thyroid disease (including goitre)	☐	☐
High or low blood pressure	☐	☐	Tuberculosis (TB)	☐	☐
Blood disorders	☐	☐	Asthma/Bronchitis/lung conditions	☐	☐
Excessive bruising or bleeding	☐	☐	Nervous system disorder	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	Anxiety/Depression	☐	☐
Kidney/renal disease	☐	☐	Gastroesophageal reflux disease (GORD)	☐	☐
Diabetes	☐	☐	Cancer or malignancy of any kind	☐	☐
Osteoporosis or low bone density	☐	☐	Chemotherapy/Radiation therapy	☐	☐
Rheumatoid arthritis/Lupus (SLE)/Polymyalgia	☐	☐	Transplanted organ/bone marrow/stem cells	☐	☐
Joint replacement surgery	☐	☐	Snoring/Sleep Apnoea	☐	☐

Have you ever smoked? Y ☐ N ☐ Approx date if quit ...... /...... /..... Do you currently smoke or vape? Y ☐ N ☐

If yes, for how long? .... How much do you smoke .... per day

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Practice Use Only: Review of Information

Patient Signature: .... Date: ...... /...... /......

Dentist Comment: ....

.... Signature .... Date: ...... /...... /......

Patient Signature: .... Date: ...... /...... /......

Dentist Comment: ....

.... Signature .... Date: ...... /...... /......

Patient Signature: .... Date: ...... /...... /......

Dentist Comment: ....

Cardiovascular conditions

Cardiovascular	Do you have any cardiovascular disease? (e.g. hypertension, heart disease)

Case: a patient with hypertension on aspirin and a history of atrial fibrillation

Discussion points

- Why do we need to know about cardiovascular disease?
- How might aspirin affect dental treatment?
- What precautions are necessary before scaling or extractions?

Bleeding disorders

Bleeding/Clotting Disorders	Do you have a bleeding or clotting disorder? Have you ever had excessive bleeding? Do you have any blood disorders (e.g. anaemia)?

Case: a 45-year-old female with von Willebrand disease scheduled for dental scaling

Discussion points

- How does a bleeding disorder affect dental treatment?
- What considerations are necessary?
- What considerations if patient has anaemia or unexplained bleeding?

Respiratory conditions

Respiratory	Do you have a respiratory disease? (e.g. asthma, emphysema)

Case: a 30-year-old asthmatic uses salbutamol regularly and has mild wheezing today

Discussion points

- How should treatment be modified?
- What emergency preparedness is required?
- How should asthma be managed in the dental setting?
- Are there any materials or procedures to avoid?

Neurological conditions

Neurological	Do you have a neurological disorder? (e.g. epilepsy)

Case: a 28-year-old with well-controlled epilepsy had a seizure 6 months ago

Discussion points

- What are the risks during dental care?
- How can seizures be prevented or managed?

Gastrointestinal conditions

Gastrointestinal	Do you have a gastrointestinal disease? (e.g. coeliac disease, inflammatory bowel disease, gastritis)

Case: a patient with Crohn's disease presents with recurrent ulcers and clinically signs of enamel wear on upper palatal

Discussion points

- What oral signs are associated with Crohn's?
- Any product sensitivities?
- Oral manifestations of some GI conditions

Endocrine conditions

Endocrine	Do you have an endocrine condition? (e.g. diabetes, thyroid disorder, dyslipidaemia)

Case: a 55-year-old with type 2 diabetes on metformin and insulin

Discussion points

- How does diabetes affect periodontal health and healing?
- What are hypoglycaemia risks?
- What are the dental implications of diabetes?
- What timing is best for appointments?

Renal/Hepatic conditions

Renal/Hepatic	Do you have kidney or liver disease? (e.g. hepatitis)

Case: a patient with stage 3 chronic kidney disease

Discussion points

- What implications for drug prescribing?
- Dental implications for his medical conditions?

Bone modifying agents

Bone-modifying agents	Have you ever taken medications such as bisphosphonates or denosumab?

Case: a patient on denosumab for osteoporosis presents for an extraction

Discussion points

- What is MRONJ and how can it be prevented?
- Should extractions be delayed or avoided?

Skin conditions

Skin conditions	Do you have any skin diseases?

Case: a patient with severe eczema and known contact dermatitis

Discussion points

- What dental materials may trigger reactions?

Psychological health

Psychological health	Do you have any psychological conditions? (e.g. anxiety, depression, dental phobia)

Case: a 25-year-old with severe dental anxiety and panic attacks

Discussion points

- How do mental health conditions affect dental care?
- How can we improve patient comfort?

Cancer/Radiation Therapy

Cancer/Radiation	Do you have a history of cancer? Have you received radiation therapy to the head or neck?

Case: a patient with a history of head and neck cancer and jaw radiotherapy

Discussion points:

- What risks persist long after radiation?
- What is osteoradionecrosis?
- Considerations when treating this patient?

Infectious disease

Infectious disease	Have you ever had an infectious disease? (e.g. tuberculosis, hepatitis, HIV)

Case: a patient discloses HIV-positive status with an undetectable viral load

Discussion points

- Are there additional infection control measures?
- Is dental treatment safe?
- Oral manifestations?

Past operations/Hospitalization/Complications

Hospitalisations	Have you had any past operations or hospitalisations? Were there any complications?

Case: patient reports allergic reaction after general anaesthesia during childhood surgery

Discussion points

- How should you investigate this history?
- Does this affect dental care?

Pregnancy

Pregnancy	Are you currently pregnant? If yes, what is your due date?

Case: a 32-year-old woman in her second trimester needing scaling and a filling

Discussion points

- Is it safe to treat during pregnancy?
- What precautions should be taken?

Allergies

Allergies	Do you have any allergies to medications, food, or chemicals?

Case: patient reports penicillin allergy as a child

Discussion points

- How should allergy be confirmed?
- What are safer alternatives?

Medication history (including complementary)

Medications	Are you currently taking any medications, including supplements?

Case: patient is on SSRIs, fish oil, and St John's Wort

Discussion points

- Why ask about supplements?
- Any drug interactions?

Recreational drug use

Recreational drug use	Have you ever used recreational drugs?

Case: patient occasionally uses cocaine and MDMA on weekends

Discussion points

- What are risks during dental procedures?
- How does drug use affect oral health?

Smoking/vaping

Smoking/Vaping	Do you currently or previously smoke or vape? Please specify product, quantity (per day/week), and duration

Case: long-term smoker, switched to vaping 6 months ago

Discussion points

- What’s the dental impact of smoking and vaping?
- Should cessation be discussed?

Alcohol use

Alcohol use	Do you consume alcohol? Please specify type of drink, amount (per day/week/month/year), and duration

Case: drinks 4 beers per night; recent liver test abnormalities

Discussion points

- What are oral and systemic impacts of alcohol?
- How does it affect treatment?