PATIENT MEDICAL HISTORY

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General Dentistry
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Scio Memorial Clinic (503) 394-3345

Patient Name _____

Are you currently under the care of a medical doctor? .....YES ❑ NO ❑

Physician's name _____

Address _____Phone# _____

Have you ever had an unfavorable reaction to dental treatment?.....YES ❑ NO ❑

Do you feel nervous about having dental treatment?.....YES ❑ NO ❑

Have you ever been Hospitalized or had a major operation? .....YES ❑ NO ❑

Have you ever had a serious head or neck injury?.....YES ❑ NO ❑

Are you taking or previously taken Fosamax, Actonel, or Bonivas?.....YES ❑ NO ❑

Do you smoke? How much? _____.....YES ❑ NO ❑

Do you use Smokeless Tobacco? How much? _____ .....YES ❑ NO ❑

Do you have any sores or growths in your mouth? Discuss: _____ .....YES ❑ NO ❑

Are you allergic to any of the following?

o Aspirin o Penicillin o Codeine o Local Anesthetics o Latex o Metals o Foods (please list)

o Other (please list) _____

For Female Patients Only:

Are you: o Pregnant / Trying to get pregnant? o Nursing? o Taking Oral Contraception, Norplant, or Injections?

Please list all prescription and non-prescription medications you are using: _____

_____

_____

Indicate which of the following that you have had or currently have?

- o AIDS / HIV Positive
- o Angina / Chest Pain
- o Arthritis
- o Artificial Heart Valve
- o Artificial joints (Hip, Knee)
- o Asthma
- o Bleeding Disorder
- o Blood Transfusion
- o Breathing Problems
- o Cancer
- o Chemotherapy
- o Cold Sores / Fever Blisters
- o Diabetes
- o Drug Addiction
- o Emphysema
- o Epilepsy / Seizures
- o Glaucoma
- o Heart Attack (Year_____)
- o Heart Condition / Disease
- o Heart Failure
- o Heart Murmur
- o Heart Pace Maker
- o Hepatitis (Type____)
- o High Blood Pressure
- o Hypoglycemia
- o Kidney Condition / Disease
- o Leukemia
- o Liver Condition / Disease
- o Mitral Valve Prolapse
- o Psychiatric Care
- o Radiation Treatments
- o Recreational Drug Use
- o Renal Dialysis
- o Rheumatic Fever
- o Stomach / Intestinal Disease
- o Stroke
- o Swelling of Ankles
- o Thyroid / Parathyroid Disease
- o Tuberculosis
- o Tumors or Growths
- o Ulcers
- o Venereal Disease

Are there any health conditions you have which are not covered by this form? (please list).....YES ❑ NO ❑

_____

_____

CONSENT: The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated, and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a ceratin risk.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

Patient or Guardian Signature Date