General and Family Dentistry
123 S.E. Douglas St.
Newport, OR 97365-0080

MEDICAL HISTORY

Patient Name ______________________ Nickname ____________ Age ______

Most recent physical examination ______________________ Purpose ______________________

Name of Physician/and their specialty ____

What is your general estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:

	YES	NO
hospitalization for illness or injury ______	☐	☐
an allergic reaction to		
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa		
☐ local anesthetic		
☐ fluoride		
☐ metals (nickel, gold, silver ________)		
☐ latex		
☐ other ______		
heart problems, or cardiac stent within the last six months ______	☐	☐
history of infective endocarditis ______	☐	☐
artificial heart valve, repaired heart defect (PFO) ______	☐	☐
pacemaker or implantable defibrillator ______	☐	☐
orthopedic implant (joint replacement) ______	☐	☐
rheumatic or scarlet fever ______	☐	☐
high or low blood pressure ______	☐	☐
a stroke (taking blood thinners) ______	☐	☐
anemia or other blood disorder ______	☐	☐
prolonged bleeding due to a slight cut (INR > 3.5) ______	☐	☐
emphysema, shortness of breath, sarcoidosis ______	☐	☐
tuberculosis, measles, chicken pox ______	☐	☐
asthma ______	☐	☐
breathing or sleep problems (i.e. sleep apnea, snoring, sinus)	☐	☐
kidney disease ______	☐	☐
liver disease ______	☐	☐
jaundice ______	☐	☐
thyroid, parathyroid disease, or calcium deficiency ______	☐	☐
hormone deficiency ______	☐	☐
high cholesterol or taking statin drugs ______	☐	☐
diabetes (HbA1c =) ______	☐	☐
stomach or duodenal ulcer ______	☐	☐
digestive disorders (i.e. celiac disease, gastric reflux) ______	☐	☐

	YES	NO
osteoporosis/osteopenia (i.e. taking bisphosphonates) ______	☐	☐
arthritis ______	☐	☐
autoimmune disease ______	☐	☐
(i.e. rheumatoid arthritis, lupus, scleroderma)		
glaucoma ______	☐	☐
contact lenses ______	☐	☐
head or neck injuries ______	☐	☐
epilepsy, convulsions (seizures) ______	☐	☐
neurologic problems (ADD/ADHD, prion disease) ______	☐	☐
viral infections and cold sores ______	☐	☐
any lumps or swelling in the mouth ______	☐	☐
hives, skin rash, hay fever ______	☐	☐
HPV ______	☐	☐
hepatitis (type _) ______	☐	☐
HIV/AIDS ______	☐	☐
tumor, abnormal growth ______	☐	☐
radiation therapy ______	☐	☐
chemotherapy, immunosuppressive medication ______	☐	☐
antidepressant medication ______	☐	☐
recreational drug use ______	☐	☐

ARE YOU:

	YES	NO
presently being treated for any other illness ______	☐	☐
aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) ______	☐	☐
taking medication for weight management (i.e. fen-phen) ______	☐	☐
taking dietary supplements ______	☐	☐
often exhausted or fatigued ______	☐	☐
experiencing frequent headaches ______	☐	☐
a smoker smoked previously or use smokeless tobacco ______	☐	☐
FEMALE- taking birth control pills ______	☐	☐
currently pregnant ______	☐	☐
MALE -prostate disorders ______	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

____

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature ______________________ **Date** ____________

Doctor's Signature ______________________ **Date** ____________

ASA _____ (1-6) ◯ ◯ ◯