Oregon Family Dental

Medical & Dental History

Name: _____

1. Why are you here to see us today? _____
2. When was your last dental visit? _____
3. What treatment was performed at your last dental visit? _____
4. What is the name of your former Dentist? _____
5. What is the name of your Medical Doctor? _____
6. When were you last hospitalized? _____

Please circle the appropriate responses:

Cancer, Chemo, Radiation Therapy ..	Yes	No	Asthma or Hay Fever ……	Yes	No
Heart Disease……	Yes	No	Drug, Alcohol, Tobacco Use ……	Yes	No
Rheumatic Fever ……	Yes	No	Sinus Trouble ……..	Yes	No
Heart Murmur ……..	Yes	No	Persistent Cough ……..	Yes	No
Heart Pacemaker ……..	Yes	No	Hepatitis ……..	Yes	No
Tuberculosis or Lung Disease …….	Yes	No	Arthritis ……	Yes	No
Abnormal Blood Pressure HIGH/LOW	Yes	No	Stroke ……..	Yes	No
Epilepsy ……..	Yes	No	Glaucoma ……	Yes	No
Anemia ……	Yes	No	Do you have any artificial joints ……..	Yes	No
AIDS / HIV ……..	Yes	No	Are you allergic to:		
Fainting Spells ……..	Yes	No	CODEINE ……	Yes	No
Prolonged bleeding when cut ……...	Yes	No	LOCAL ANESTHETIC ……..	Yes	No
Diabetes ……..	Yes	No	PENICILLIN ……	Yes	No
Ulcers ……	Yes	No	Any other Allergies? _____		
Jaundice ……	Yes	No	_____		
Are you taking any medication? ……	Yes	No	_____		

If YES, list here: _____
_____
_____
_____

WOMEN:

Are you taking Oral Contraceptives?	Yes	No
Are you Pregnant? ……	Yes	No

Due Date: _____

Signature or Guardian's Signature

Today's Date

Office Staff

MEDICAL HISTORY REVIEW

Date	Changes	Date	Changes