Bryan R. Guthrie, D.M.D. P.C.
802 Molalla Ave.
Oregon City, OR 97045

Patient's Name: _____

Welcome! *So that we may provide you with the best possible care, please complete these medical/dental history forms. All information is completely confidential.*

Physician's Name _____ Phone _____
Address _____ City _____ State _____

1. Have you been under the care of a medical doctor during the past two years? ..... Yes No
   If yes, for what? _____

2. Are you taking any prescribed or non-prescription medications? ..... Yes No
   If yes, please list name and dosage _____
   _____

3. Are you aware of having an allergic or adverse reaction to any medication or substance? ..... Yes No
   If yes, please list: _____

4. Do you now have, or have you ever had any of the following: **Circle** "Yes" or "No" to each item.

Heart(Surgery, Disease, Attack)	yes	no	Ulcers	yes	no	Hepatitis A, B, or other	yes	no
Chest Pain	yes	no	Diabetes	yes	no	Venereal Disease	yes	no
Congenital Heart Disease	yes	no	Thyroid Problems	yes	no	A.I.D.S.	yes	no
Heart Murmur	yes	no	Glaucoma	yes	no	H.I.V. Positive	yes	no
High Blood Pressure	yes	no	Anemia	yes	no	Cold Sores, Fever Blisters	yes	no
Mitral Valve Prolapse	yes	no	Emphysema	yes	no	Bruise Easily	yes	no
Heart Pacemaker	yes	no	Tuberculosis	yes	no	Hemophilia	yes	no
Rheumatic Fever	yes	no	Asthma	yes	no	Kidney Disease	yes	no
Arthritis	yes	no	Hay Fever	yes	no	Liver Disease	yes	no
Cortisone Medicine	yes	no	Latex Sensitivity	yes	no	Neurological Disorders	yes	no
Swollen Ankles	yes	no	Allergies or Hives	yes	no	Epilepsy or Seizures	yes	no
Stroke	yes	no	Sinus Trouble	yes	no	Fainting or Dizzy Spells	yes	no
Artificial Joints	yes	no	Radiation Therapy	yes	no	Psychiatric Care	yes	no
Cancer	yes	no	Chemotherapy	yes	no			

5. Do you have or have you had any disease, condition, or problem not listed? ..... Yes No
   If Yes, please list: _____

6. Do you use tobacco products? Yes No Have you used them in the past? Yes No

7. Women: Are you: Pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider who may release such information to you. I will notify the doctor of any changes in my health or medication.

Patient / Guardian Signature _____ Date _____