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TIGARD, OR 97224

MEDICAL HISTORY FORM

Name: ______________________________________ Date: ______________________________________

Date of Birth: _________________________________ Sex: M / F Height:____________Weight: ______________________________________

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

1. Are you in good health? .... Yes No
2. Has there been any change in your health in the past year? .... Yes No
3. My last physical exam was on ________/________/________
4. Are you now under the care of a physician? .... Yes No
   If so, for what condition?____
5. The name and address of my physician is:____
   ____
6. Have you had any serious illness, operation or hospitalization within the past 5 years? .... Yes No
7. Do you have an artificial joint? .... Yes No
   If so, please list____
8. Are you taking any medicine(s) including non-prescription, homeopathic or “natural” remedies including diet pills .... Yes No
   If so, please list____
9. Do you have or have you had any of the following diseases or problems?
   a. Damaged heart valves, artificial valves or heart murmur .... Yes No
   b. Rheumatic Heart Disease .... Yes No
   c. Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis or any other heart condition .... Yes No
      1. Chest pain upon exertion? .... Yes No
      2. Shortness of breath after mild exercise? .... Yes No
      3. Do your ankles swell? .... Yes No
   d. Allergies .... Yes No
   e. Sinus trouble .... Yes No
   f. Asthma or hay fever .... Yes No
   g. Fainting spells or seizures .... Yes No
   h. Diabetes .... Yes No
   i. Hepatitis, jaundice or liver disease .... Yes No
   j. Frequent or recurring mouth sores .... Yes No
   k. Thyroid problems .... Yes

No
l. Respiratory problems, emphysema, bronchitis, etc.......Y e s
No
m. Arthritis or painful, swollen joints including jaw joint (TMJ).......Y e s
No
n. Stomach ulcer or hyperacidity.......Y e s
No
o. Kidney trouble.......Y e s
No
p. Tuberculosis.......Y e s
No
q. Persistent cough or cough that produces blood.......Y e s
No
r. Persistent swollen neck glands.......Y e s
No
s. Low blood pressure.......Y e s
No
t. Epilepsy or neurological disorder.......Y e s
No
u. Are you taking vitamins or homeopathic remedies.......Y e s
No
v. Cancer.......Y e s
No
w. Any disease, drug or transplant operation that has depressed your immune system.......Y e s
No
10. Have you had abnormal bleeding?.......Y e s
No
a. Have you ever required a blood transfusion?.......Y e s
No
11. Do you have any blood disorder such as anemia?.......Y e s
No

12. Have you ever had treatment for a tumor or growth?.......Yes No
13. Are you allergic to or have you had a reaction to:
a. Local anesthetics.......Yes No
b. Penicillin or antibiotics.......Yes No
c. Sulfa drugs.......Yes No
d. Barbiturates or sleeping pills.......Yes No
e. Aspirin.......Yes No
f. Iodine.......Yes No
g. Codeine or other narcotics.......Yes No
h. Latex or rubber products.......Yes No
i. Other.......Yes No

14. Have you had any serious trouble associated with previous dental treatment?.......Yes No
If so, explain:____
____
15. Do you have any other condition or disease you think the doctor should know about?.......Yes No
If so, explain:____
16. Are you taking or have you ever taken Bisphosphonates (Fosamax, Actonel, for osteoporosis, chemotherapy for multiple myeloma, etc.) ?.......Yes No
17. Are you wearing contact lenses?.......Yes No
18. Are you wearing removable dental appliances?.......Yes No
19. Do you wish to talk with the doctor privately about anything?.......Yes No

No

Women
20. Are you pregnant or trying to become pregnant.......Yes No
21. Do you have problems associated with your menstrual period?.......Yes No
22. Are you nursing?.......Yes No
23. Are you taking birth control pills?.......Yes No

Chief Dental Complaint: ____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Date:________________________ Patient's Signature:____

FOR COMPLETION BY THE DOCTOR

Comments on patient interview concerning medical history: ____

Significant findings from questionnaire or oral interview: ____

Dental management considerations: ____

Date:________________________ Doctor's Signature:____