

Patient Health History

Patient: _____

Name of Primary Physician:	Date of Last Physical:	Phone:
In Case of an Emergency, The Name of A Friend or Relative:		
Their Phone:	Their Address:	

Have you been hospitalized or had any serious illness during the past five years? Yes No
If so, please explain: _____

Have there been any changes in your health during the last year? Yes No
If so, please explain: _____

Are you under a Physician's care now? Yes No What is your Blood Pressure: ____/____

Have you ever had any of the following: (Please Check)

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Artificial Joints |
| <input type="checkbox"/> HIV Virus (AIDS) | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Cancer | <input type="checkbox"/> Other |
| <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> An Abnormal Heart Condition | <input type="checkbox"/> Psychiatric Care | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Abnormal Bleeding from a Cut | <input type="checkbox"/> Emphysema | _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma | _____ |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Stroke | _____ |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Drug/Alcohol Abuse Tx | |

If so, Please explain: _____

Do you have allergies to: (Please Circle)

Penicillin, Local Anesthetics, Sulfa Drugs, Barbiturates, Metals (nickel, etc.), Sedatives, Sleeping Pills, Aspirin, Iodine, Codeine, Narcotics, Or Any Other Medication or Drug

If so, please explain: _____

Are you taking any of the following: (Please Check)

- | | | | |
|--|--|---|-----------------------------------|
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Medicine for Blood Pressure | <input type="checkbox"/> Antihistamines | <input type="checkbox"/> Vitamins |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Digitalis for Heart Problems | <input type="checkbox"/> Insulin | <input type="checkbox"/> Other |
| <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Cortisone (steroids) | <input type="checkbox"/> Tolbutamide(Orinase) | _____ |
| <input type="checkbox"/> Anticoagulants (blood thinners) | <input type="checkbox"/> Tranquilizers (Valium) | <input type="checkbox"/> Antipsychotic(Thorazine) | _____ |
| <input type="checkbox"/> Nitroglycerin | <input type="checkbox"/> Antidepressants (MAO Inhibitor) | <input type="checkbox"/> Birth Control | _____ |

If so, which and how often: _____

Do you have any diseases or conditions not mentioned above? Yes No
If so, please explain: _____

Do you use tobacco products? Yes No
If so, how often: _____

Does anyone in your family have diabetes? Yes No
If so, please explain: _____

Women: Are you Pregnant? _____ Due Date: _____ Yes No

"I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I am responsible to inform this office of any change in my medical history before dental treatment"

Patient Signature: _____ Date: _____
(or parent or guardian if minor)

Patient Health History (Continued)

Patient: _____

Have you had an orthopedic total joint (hip, knee, elbow, etc) replacement? Yes No

If yes, when was the operation done? _____

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Yes No

If yes, what antibiotic and dose? _____

DENTAL HISTORY

What is the primary purpose for this visit? _____

Have you ever had any of the following: (Please Circle)

Orthodontics, Oral Surgery, Periodontal Surgery, Root Canal Treatment, Implants, Cosmetic Dentistry

If so, please explain: _____

How many times a day do you brush your teeth? _____ Floss? _____

Do you have any of the following: (Please Circle)

Bleeding Gums, Dry Mouth, Itching Gums, Pain When Chewing, Sensitivity to Hot, Cold, Air, or Sweets

If so, please explain: _____

Have you had any major dental treatment during the past five years? Yes No

If so, please explain: _____

Are you aware of any changes in your dental health during the last year? Yes No

If so, please explain: _____

Have you ever had health problems with dental treatment? Yes No

If so, please explain: _____

Have you had any periodontal (gum) treatments? Yes No

If so, please explain: _____

Are you apprehensive about receiving dental care? Yes No

If so, please explain: _____

Are you happy with the appearance of your teeth? Yes No

If no, please explain: _____

Do you have problems becoming numb from dental anesthetic? Yes No

If so, please explain: _____

Nitrous Oxide (laughing gas) is available for a small fee. Are you interested? Yes No

*Nitrous Oxide is not available to those who are pregnant, or have had recent eye or ear surgery.

If you are going to receive Nitrous Oxide, be sure to have a light, non-greasy meal two hours beforehand.

If you're interested, please sign your consent to receive Nitrous Oxide at Gresham Downtown Dental Group:

Patient Signature: _____

(or parent or guardian if minor)

Date: _____