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)

☐ Anemia	☐ Tuberculosis	☐ Stomach Ulcers	☐ Artificial Joints
☐ HIV Virus (AIDS)	☐ Heart Murmur	☐ Cancer	☐ Other
☐ Venereal Disease	☐ An Abnormal Heart Condition	☐ Psychiatric Care	_____
☐ Diabetes	☐ Abnormal Bleeding from a Cut	☐ Emphysema	_____
☐ Epilepsy	☐ High Blood Pressure	☐ Asthma	_____
☐ Hepatitis	☐ Low Blood Pressure	☐ Stroke	_____
☐ Rheumatic Fever	☐ Kidney Problems	☐ 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)

☐ Antibiotics	☐ Medicine for Blood Pressure	☐ Antihistamines	☐ Vitamins
☐ Aspirin	☐ Digitalis for Heart Problems	☐ Insulin	☐ Other
☐ Sulfa Drugs	☐ Cortisone (steroids)	☐ Tolbutamide(Orinase)	_____
☐ Anticoagulants (blood thinners)	☐ Tranquilizers (Valium)	☐ Antipsychotic(Thorizine)	_____
☐ Nitroglycerin	☐ Antidepressants (MAO Inhibitor)	☐ 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)

Gresham Dental Group
Address: 315 NW Burnside Rd. Gresham, OR 97030 **Telephone: (503) 666-5484**

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: _____ **Date**: _____
(or parent or guardian if minor)