Medical History

Mt Hood Dental Clinic
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Patient _______________ Birthdate _______________ Entry Date: _______________

Medical Information

Primary Physician: _______________ Phone Number: _______________

Are you currently under a doctor's care? _______________

If yes, please describe: _______________

Have you been hospitalized or had any surgeries in the last 5 years? _______________

If yes, please list treatment and/or surgery: _______________

Women: Are you pregnant? _______________ Due Date: _______________ Are you nursing? _______________

Do you smoke?
◯ Yes ◯ No

Packs per day: _______________ How long? _______________

Do you use alcohol?
◯ Yes ◯ No

How often? _______________

Have you ever had an unfavorable reaction following dental treatment? _______________

Describe reaction: _______________

Are you sensitive or allergic to: ☐ Penicillin ☐ Codeine ☐ Tetracycline ☐ Erythromycin ☐ Sulfa Drugs ☐ Metals ☐ Latex ☐ Sedatives ☐ Dental Anesthetics

List allergen and describe reaction: _______________

Are you allergic to any other medications, drugs or treatments? _______________

If yes, please explain: _______________

Have you taken in the past 12 years, or are you currently taking, any bisphosphonate medications? _______________

If yes, how long? _______________ Please indicate which medication: ☐ Actonel ☐ Fosamax ☐ Zometa ☐ Other

If other, please list medication: _______________

Are you taking any drugs or medications at this time? _______________

Current medications you are taking: _______________

Medical History

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Medical Conditions

Do you have or have you experienced any of the following? Please check all that apply.

- ☐ AIDS/HIV
- ☐ Abnormal Bleeding
- ☐ Alcohol Addiction
- ☐ Alzheimer's or Dementia
- ☐ Anemia
- ☐ Arthritis/Gout
- ☐ Artificial Pins, Bones or Joints
  When: ______________
  Where: ______________
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Thinners
- ☐ Blood Transfusion
- ☐ Cancer/Tumors
  List Type: ______________
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Chicken Pox
- ☐ Cold Sores
- ☐ Colitis
- ☐ Congenital Heart Defect
- ☐ Diabetes
  Type: ______________
- ☐ Difficulty Breathing
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Fainting or Dizzy Spells
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Headaches
- ☐ Hearing Problem
- ☐ Heart Attack
  Date: ______________
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Surgery
  Type of surgery: ______________
- ☐ Heart Trouble
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lupus
- ☐ Mitral Valve Prolapse
- ☐ Neurological Disorders
  Disorder: ______________
- ☐ Osteoporosis
- ☐ Pacemaker
  Date Placed: ______________
  Type placed: ______________
- ☐ Persistent Cough
- ☐ Psychiatric Problems
- ☐ Radiation Therapy
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizure Disorder
- ☐ Sexually Transmitted Disease
- ☐ Shingles
- ☐ Shortness of Breath
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Stroke/CVA
- ☐ Thyroid Disease
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Ulcers/Acid Reflux
- ☐ Other

Please list any serious medical conditions(s) not indicated above that you have expeienced in the last 5 years:

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Emergency Contact: ______________ Phone: ______________ Relationship: ______________

By signing this form, I acknowledge that the information provided is true and accurate to the best of my knowledge.

Patient Signature:

X ______________________________

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Signer's Full Name Date