

PATIENT MEDICAL HISTORY



Douglas M. Johnson, D.M.D.
General Dentistry

2380 14th Ave. SE, Albany (541) 928-5414
Scio Memorial Clinic (503) 394-3345

Patient Name _____

Are you currently under the care of a medical doctor?YES NO

Physician's name _____

Address _____ Phone# _____

Have you ever had an unfavorable reaction to dental treatment?YES NO

Do you feel nervous about having dental treatment?YES NO

Have you ever been Hospitalized or had a major operation?YES NO

Have you ever had a serious head or neck injury?YES NO

Are you taking or previously taken Fosamax, Actonel, or Bonivas?YES NO

Do you smoke? How much? _____YES NO

Do you use Smokeless Tobacco? How much? _____YES NO

Do you have any sores or growths in your mouth? Discuss: _____YES NO

Are you allergic to any of the following?

Aspirin Penicillin Codeine Local Anesthetics Latex Metals Foods (please list)

Other (please list) _____

For Female Patients Only:

Are you: Pregnant / Trying to get pregnant? Nursing? Taking Oral Contraception, Norplant, or Injections?

Please list all prescription and non-prescription medications you are using: _____

Indicate which of the following that you have had or currently have?

- | | | | |
|---|---|--|---|
| <input type="radio"/> AIDS / HIV Positive | <input type="radio"/> Chemotherapy | <input type="radio"/> Heart Murmur | <input type="radio"/> Recreational Drug Use |
| <input type="radio"/> Angina / Chest Pain | <input type="radio"/> Cold Sores / Fever Blisters | <input type="radio"/> Heart Pace Maker | <input type="radio"/> Renal Dialysis |
| <input type="radio"/> Arthritis | <input type="radio"/> Diabetes | <input type="radio"/> Hepatitis (Type____) | <input type="radio"/> Rheumatic Fever |
| <input type="radio"/> Artificial Heart Valve | <input type="radio"/> Drug Addiction | <input type="radio"/> High Blood Pressure | <input type="radio"/> Stomach / Intestinal Disease |
| <input type="radio"/> Artificial joints (Hip, Knee) | <input type="radio"/> Emphysema | <input type="radio"/> Hypoglycemia | <input type="radio"/> Stroke |
| <input type="radio"/> Asthma | <input type="radio"/> Epilepsy / Seizures | <input type="radio"/> Kidney Condition / Disease | <input type="radio"/> Swelling of Ankles |
| <input type="radio"/> Bleeding Disorder | <input type="radio"/> Glaucoma | <input type="radio"/> Leukemia | <input type="radio"/> Thyroid / Parathyroid Disease |
| <input type="radio"/> Blood Transfusion | <input type="radio"/> Heart Attack (Year_____) | <input type="radio"/> Liver Condition / Disease | <input type="radio"/> Tuberculosis |
| <input type="radio"/> Breathing Problems | <input type="radio"/> Heart Condition / Disease | <input type="radio"/> Mitral Valve Prolapse | <input type="radio"/> Tumors or Growths |
| <input type="radio"/> Cancer | <input type="radio"/> Heart Failure | <input type="radio"/> Psychiatric Care | <input type="radio"/> Ulcers |
| | | <input type="radio"/> Radiation Treatments | <input type="radio"/> Venereal Disease |

Are there any health conditions you have which are not covered by this form? (please list)YES NO

CONSENT: The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated, and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a ceratin risk.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient or Guardian Signature

Date