South Eugene Family Dental 2021

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c
Thank you for answering the following questions.

Do you have a general Physician or Specialist?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, herbals, marijuana or drugs?	◯ Yes ◯ No	If yes
Have you been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Have you had a CAT scan in the last year?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva or any osteoporosis medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Do you take a pre-med before your dental appointment? If so, what do you take and what for?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	If yes
How many Sodas per day do you drink?	◯ Yes ◯ No	If yes
Do you use tobacco? If so - how much?	◯ Yes ◯ No	If yes
Do you drink alcohol? If so - how much?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Latex
☐ Metal	☐ Fluoride	☐ Amoxicillin	☐ Local Anesthetics
☐ Ibuprofen	☐ Sulfa		

Other allergies?	◯ Yes ◯ No	If yes
Do you have any disease, problem or condition not listed?	◯ Yes ◯ No	If yes

Do you have, or have you had, any of the following? Only Mark Yes if they apply

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Anaphylaxis	◯ Yes ◯ No	Anxiety	◯ Yes ◯ No
Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No	Anemia	◯ Yes ◯ No	Herpes	◯ Yes ◯ No
Rheumatic Fever	◯ Yes ◯ No	Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No
Rheumatism	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No	Artificial Heart Valve	◯ Yes ◯ No
Excessive Bleeding	◯ Yes ◯ No	Shingles	◯ Yes ◯ No	Artificial Joint	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No
Sickle Cell Disease	◯ Yes ◯ No	Asthma	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No
Stomach/Intestinal Disease	◯ Yes ◯ No	Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No
Stroke	◯ Yes ◯ No	Bruise Easily	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Cancer	◯ Yes ◯ No
Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No	Chemotherapy	◯ Yes ◯ No
Mitral Valve Prolapse	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Heart Murmur	◯ Yes ◯ No	Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No
Hard of Hearing	◯ Yes ◯ No	MRSA	◯ Yes ◯ No	Dry Mouth	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No
Drug Addiction	◯ Yes ◯ No						

Have you ever had any serious illness not listed above?	◯ Yes ◯ No	If yes

Comments:

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.

Signature of Patient, Parent or Guardian:

X Date:_____