Southwest Portland Dental
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MEDICAL AND DENTAL HISTORY

NAME:_____

Regular physician_____Date of last visit_____

1. Are you now or have you been within the last year under a physician's care?_____
   If yes, for what purpose?_____

2. Have you had any of the following conditions? (Please circle all that apply)

Heart murmurs	High or low blood pressure
Heart conditions	Diabetes
Respiratory disease	Arthritis
Cancer	Blood disease or bleeding problems
Liver disease or hepatitis	Alcohol/drug problem or dependence
AIDS or related disorders	Stroke

   Other Medical Conditions_____

3. Do you have congenital heart disease, artificial heart valve, artificial hip or other joint, or any condition which require you to take antibiotics priot to dental procedures?_____

4. Have you had any major operations in the past two years?_____
   If yes, please describe_____

5. Are you allergic to any of the following substances:

Aspirin	Penicillin	Other Antibiotics_____
Codeine	Local anesthetic	Latex gloves or materials
Any metals_____	Other drugs or substances_____	

6. Are you taking any drugs, prescriptions or medications?_____
   If yes, what kind?_____

7. Are you in good health at this time?_____
8. Are there any growths, unhealed, or inflamed areas in your mouth?_____
9. Do you have pain or noise in your jaw joints?_____
10. Do you habitually grind or clench your teeth?_____
11. Do you have bleeding gums?_____
12. Do you have any dental problems with which you are concerned?_____
    If yes, please explain_____
13. Do you smoke or chew tobacco?_____ If yes, quantity per day and for how many years?_____/per day _____years
14. (Women only) Are you now pregnant?_____Due date_____

Signature of patient_____**Date**_____

Update_____ _____ _____
_____ _____ _____
_____ _____ _____