Gates Family Dentistry of Wilsonville, PC

MEDICAL HISTORY

Patient Name: Parent/Guardian: Address: City: State: Zip:		Date of Birth: Relationship to Patient: Best Contact #:	
Current Physician:		Physician's Contact #:	

Welcome to Gates Family Dentistry! 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, could have an important inter-relationship with the dentistry you will receive. All information is completely confidential.

	Yes	No
Have you had any medical care within the past two years? If Yes, please describe:	☐	☐
Have you taken any medication or drugs during the past two years? If Yes, list name and dosage(s):	☐	☐
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? If Yes, list name and dosage(s):	☐	☐
Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin? If Yes, list name and dosage(s):	☐	☐
Are you aware of having an allergic (or adverse) reaction to any substance or medication? If Yes, please specify:	☐	☐
Have you ever been hospitalized or had a major operation, in the past five years? If Yes, please describe:	☐	☐
Do you use tobacco? (Including smokeless tobacco)	☐	☐

Please indicate which of the following you have had, or presently have:

	Yes	No		Yes	No		Yes	No		Yes	No
AIDS/HIV Positive	☐	☐	Cortisone Medicine	☐	☐	Hemophilia	☐	☐	Radiation Treatments	☐	☐
Alzheimer's Disease	☐	☐	Diabetes	☐	☐	Hepatitis A	☐	☐	Recent Weight Loss	☐	☐
Anaphylaxis	☐	☐	Drug Addiction	☐	☐	Hepatitis B or C	☐	☐	Renal Dialysis	☐	☐
Anemia	☐	☐	Easily Winded	☐	☐	Herpes	☐	☐	Rheumatic Fever	☐	☐
Angina	☐	☐	Emphysema	☐	☐	High Blood Pressure	☐	☐	Rheumatism	☐	☐
Arthritis/Gout	☐	☐	Epilepsy or Seizures	☐	☐	High Cholesterol	☐	☐	Scarlet Fever	☐	☐
Artificial Heart Valve	☐	☐	Excessive Bleeding	☐	☐	Hives or Rash	☐	☐	Shingles	☐	☐
Artificial Joint	☐	☐	Excessive Thirst	☐	☐	Hypoglycemia	☐	☐	Sickle Cell Disease	☐	☐
Asthma	☐	☐	Fainting Spells/Dizziness	☐	☐	Irregular Heartbeat	☐	☐	Sinus Trouble	☐	☐
Blood Disease	☐	☐	Frequent Cough	☐	☐	Kidney Problem	☐	☐	Spina Bifida	☐	☐
Blood Transfusion	☐	☐	Frequent Diarrhea	☐	☐	Leukemia	☐	☐	Stomach/Intestinal Disease	☐	☐
Breathing Problem	☐	☐	Frequent Headaches	☐	☐	Liver Disease	☐	☐	Stroke	☐	☐
Bruise Easily	☐	☐	Genital Herpes	☐	☐	Low Blood Pressure	☐	☐	Swelling of Limbs	☐	☐
Cancer	☐	☐	Glaucoma	☐	☐	Lung Disease	☐	☐	Thyroid Disease	☐	☐
Chemotherapy	☐	☐	Hay Fever	☐	☐	Mitral Valve Prolapse	☐	☐	Tonsillitis	☐	☐
Chest Pain	☐	☐	Heart Attack/Failure	☐	☐	Osteoporosis	☐	☐	Tuberculosis	☐	☐
Cold Sores/Fever Blisters	☐	☐	Heart Murmur	☐	☐	Pain in Jaw Joints	☐	☐	Ulcers	☐	☐
Congenital Heart Disease	☐	☐	Heart Pacemaker	☐	☐	Parathyroid Disease	☐	☐	Venereal Disease	☐	☐
Convulsions	☐	☐	Heart Trouble/Disease	☐	☐	Psychiatric Care	☐	☐	Jaundice (Yellowing)	☐	☐

	Yes	No		Yes	No
WOMEN: Are you pregnant or think you could be pregnant?	☐	☐	Nursing?	☐	☐
Do you use birth control prescriptions?					

Submit

Doctor Verified: _____ Date: _____

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