Newberg FAMILY DENTAL
YOUR LOCAL family DENTIST

General Medical Information:

Please circle your response (DK = don't know)

YES NO DK Are you, or have you been in the past year, seen by a primary care provider?
If yes, please list name and location: _____

YES NO DK Are you seen by any medical specialists? If yes, please list name(s) and location(s): _____
_____

YES NO DK Do you have active tuberculosis or have you been exposed to anyone with tuberculosis?

YES NO DK Have you had heart surgery? If yes, please specify: STENTS VALVES BYPASS(CABG) Other: _____
Date(s) and any complications: _____

YES NO DK Have you had an organ/bone marrow transplant?

YES NO DK Have you had an orthopedic total joint replacement?

YES NO DK Do you now or have you ever had cancer? If yes, how was it treated? _____

YES NO DK Have you had any serious illness, surgery, or been hospitalized? If yes, how long ago?
0-12 months 1-5 year > 5 years

YES NO DK Do you use or have you used tobacco products? If yes, please specify type:
CIGARETTES E-CIGARETTES CIGARS PIPES HOOKAH CHEW OTHER: _____
☐ PAST: When did you stop: _____ How many years of use: _____
☐ CURRENT: ☐ >10 per day ☐ <10 per day ☐ occasionally For how many years: _____
Are you interested in stopping? VERY SOMEWHAT NOT INTERESTED

YES NO DK Do you drink alcoholic beverages? If yes, daily? YES NO DK How many drinks per week? _____

YES NO DK Do you use or have you used street drugs, prescription, or other substances for recreational purposes?
☐ PAST ☐ CURRENT Are you drug dependent? YES NO DK Last use: _____
(specify): COCAINE ECSTASY HEROIN MARIJUANA METH OPIOIDS OTHER: _____

Females Only:

YES NO DK Are you or could you be pregnant? If yes, number of weeks: _____ due date: _____

YES NO DK Are you nursing?

YES NO DK Are you taking any of the following? Birth Control Fertility drugs Hormone Replacement

Allergies to Drugs, Latex, Metals, or Foods:

YES NO DK Are you allergic to or have you had a reaction to any of the following? Please specify type of reaction.

☐ Local anesthetics (Lidocaine/Epinephrine)
☐ Penicillin
☐ Sulfa drugs
☐ Other antibiotics: _____
☐ Aspirin
☐ Advil (Ibuprofen)
☐ Tylenol (acetaminophen)
☐ Codeine
☐ Opioids (hydrocodone, oxycodone)
☐ Chlorhexidine mouth rinse (Peridex/Periguard)
☐ Iodine
☐ Other medication(s): _____
☐ Latex
☐ Metals/Jewelry (nickel/chrome)
☐ Dietary allergies _____
☐ Other: _____

Current Medications:

_____

_____

Medical Conditions:

YES NO DK Eye/Ear /Nose/Throat problem
If yes, please specify:
- ☐ Vision problems
  - ☐ Corrective lenses
  - ☐ Cataracts
  - ☐ Glaucoma
    - ☐ Narrow angle/open
- ☐ Hearing impairment
- ☐ Hay fever/seasonal
- ☐ Other: _____

YES NO DK Heart/Blood Pressure problem
If yes, please specify:
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Infective endocarditis
- ☐ Congenital heart defect/disease
- ☐ Angina (chest pain)
- ☐ Heart attack
- ☐ Heart failure
- ☐ Coronary heart disease
- ☐ Arrhythmia (irregular heart beat)
- ☐ Pacemaker/implanted defibrillator
- ☐ Other: _____

YES NO DK Breathing/Lung problem
If yes, please specify:
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Sinusitis
- ☐ Pneumonia
- ☐ Obstructive sleep apnea
  - ☐ Use CPAP/BiPAP
  - ☐ Surgical Correction
  - ☐ Oral appliance
- ☐ Other: _____

YES NO DK Stomach/Intestine/Liver problem
If yes, please specify:
- ☐ Acid reflux (GERD)
- ☐ Ulcers
- ☐ Crohn's disease
- ☐ IBS (irritable bowel syndrome)
- ☐ Ulcerative Colitis
- ☐ Celiac disease
- ☐ Hepatitis
  - ☐ A ☐ B/D ☐ C
- ☐ Cirrhosis
- ☐ Other: _____

YES NO DK Eating Disorder
If yes, please specify:
- ☐ Bulimia
- ☐ Anorexia
- ☐ Other: _____

YES NO DK Kidney/Urinary problem
If yes, please specify:
- ☐ Chronic kidney disease
- ☐ Renal failure/dialysis
- ☐ Bladder problems
- ☐ Urinary incontinence
- ☐ BPH
- ☐ Other: _____

YES NO DK Muscle/Bone disorder
If yes, please specify:
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Gout
- ☐ Temporomandibular joint disorder
- ☐ Fibromyalgia
- ☐ Other: _____

YES NO DK Skin Problem
If yes, please specify:

_____

YES NO DK Neurologic/Nerve problem
If yes, please specify:
- ☐ Stroke/TIA
- ☐ Seizures/Epilepsy
- ☐ Multiple Sclerosis
- ☐ Parkinson's disease
- ☐ Neuropathies (tingling, numbness)
- ☐ Dementia/Alzheimer's
- ☐ Autism
- ☐ Headache
- ☐ Other: _____

YES NO DK Mental Health disorder
If yes, please specify:
- ☐ Bipolar disorder
- ☐ Depression
- ☐ Schizophrenia
- ☐ PTSD
- ☐ ADD/ADHD
- ☐ Generalized anxiety disorder
- ☐ Panic attacks
- ☐ Other: _____

YES NO DK Diabetes/Endocrine disorder
If yes, please specify:
- ☐ Diabetes
  - ☐ Type 1 ☐ Type 2 A1C___
- ☐ Thyroid problems
  - ☐ Hypothyroidism (low)
  - ☐ Hyperthyroidism (high)
- ☐ Other: _____

YES NO DK Blood/Hematologic disorder
If yes, please specify:
- ☐ Anemia
- ☐ Sickle cell disease/trait
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Multiple myeloma
- ☐ Bleeding disorders
  - ☐ Hemophilia
  - ☐ Von Willebrand disease
  - ☐ Thrombocytopenia (low platelets)

  INR(if known) _____
- ☐ Other: _____

YES NO DK Immune System disorder
If yes, please specify:
- ☐ Lupus erythematosus
- ☐ Rheumatoid arthritis
- ☐ Sjogren's syndrome
- ☐ Other: _____

YES NO DK Infectious disease
If yes, please specify:
- ☐ HIV/AIDS
- ☐ STD
- ☐ Cold Sores
- ☐ Other: _____

YES NO DK Do you have any other problem, disease, or condition no listed above?
If yes, please specify:

_____
_____
_____
_____
_____
_____
_____
_____

_____ _____ _____ _____
Signature of patient or responsible party | Date | Dentist's Signature | Date