UNIVERSITY OF OREGON

University Health Center
UO Dental Clinic Medical History

Patient Name: Birth Date: UO ID:

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 interrelationship with dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes ☐ No ☐
If yes, please explain:

Have you ever been hospitalized or had a major operation? Yes ☐ No ☐
If yes, please explain:

Have you ever had a serious head or neck injury? Yes ☐ No ☐
If yes, please explain:

Are you on a special diet? Yes ☐ No ☐
If yes, please explain:

Have you had your Flu Vaccine for 2016-2017? Yes☐ No ☐

Do you use tobacco products? Yes ☐ No ☐
If yes, what type/amount/how long:

Do you drink Alcohol? Yes ☐ No ☐
If yes, how much and how often?

Do you need to pre-medicate before treatment? Yes ☐ No ☐
If yes, please explain:

List **ALL** medications you are currently taking:

Do you use illicit drugs? Yes ☐ No ☐
If yes, please explain:

Marijuana use? Yes ☐ No ☐

Are you **allergic to any medication**? Yes ☐ No ☐
If yes, please list:

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WOMEN: Are you….
Pregnant/Trying to get pregnant ☐ Nursing ☐ Taking Oral Contraceptives ☐

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes☐ No☐	Bruise Easily	Yes☐ No☐
Diabetes	Yes☐ No☐	Glaucoma	Yes☐ No☐
Drug Addiction	Yes☐ No☐	Hay Fever	Yes☐ No☐
Herpes	Yes☐ No☐	Heart Attack	Yes☐ No☐
High Blood Pressure	Yes☐ No☐	Heart Murmur	Yes☐ No☐
High Cholesterol	Yes☐ No☐	Heart Pacemaker	Yes☐ No☐
Hives or Rash	Yes☐ No☐	Heart Disease	Yes☐ No☐
Hypoglycemia	Yes☐ No☐	MRSA	Yes☐ No☐
Irregular Heartbeat	Yes☐ No☐	Hemophilia	Yes☐ No☐
Kidney Problems	Yes☐ No☐	Recent Weight Loss	Yes☐ No☐
Stomach/Intestinal Disease	Yes☐ No☐	Angina	Yes☐ No☐
Stroke	Yes☐ No☐	Renal Dialysis	Yes☐ No☐
Cancer	Yes☐ No☐	Arthritis/Gout	Yes☐ No☐
Chemotherapy	Yes☐ No☐	Artificial Heart Valve	Yes☐ No☐
Chest Pains	Yes☐ No☐	Artificial Joint	Yes☐ No☐
Cold Sores/Fever Blisters	Yes☐ No☐	Asthma	Yes☐ No☐
Congenital Heart Disorder	Yes☐ No☐	Blood Disease	Yes☐ No☐
Convulsions	Yes☐ No☐	Frequent Diarrhea	Yes☐ No☐
Eating Disorder	Yes☐ No☐	Low Blood Pressure	Yes☐ No☐
Cortisone Medicine	Yes☐ No☐	Lung Disease	Yes☐ No☐
Hepatitis A	Yes☐ No☐	Mitral Valve Prolapse	Yes☐ No☐
Hepatitis B or C	Yes☐ No☐	Osteoporosis	Yes☐ No☐
Rheumatic Fever	Yes☐ No☐	Pain in Jaw Joints	Yes☐ No☐
Rheumatism	Yes☐ No☐	Parathyroid Disease	Yes☐ No☐
Scarlet Fever	Yes☐ No☐	Psychiatric Care	Yes☐ No☐
Shingles	Yes☐ No☐	Radiation Treatments	Yes☐ No☐
Sickle Cell Disease	Yes☐ No☐	Anaphylaxis	Yes☐ No☐
Sinus Trouble	Yes☐ No☐	Anemia	Yes☐ No☐
Blood Transfusion	Yes☐ No☐	Emphysema	Yes☐ No☐
Breathing Problems	Yes☐ No☐	Epilepsy or Seizures	Yes☐ No☐
Excessive Bleeding	Yes☐ No☐	Excessive Thirst	Yes☐ No☐
Fainting Spells/Dizziness	Yes☐ No☐	Frequent Cough	Yes☐ No☐
Leukemia	Yes☐ No☐	Liver Disease	Yes☐ No☐

Swelling of Limbs	Yes☐ No☐	Thyroid Disease	Yes☐ No☐
Tonsillitis	Yes☐ No☐	Tuberculosis	Yes☐ No☐
Tumors or Growths	Yes☐ No☐	Ulcers	Yes☐ No☐
Yellow Jaundice	Yes☐ No☐		

Have you had any serious illness NOT listed above?

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:

Date: