

Aaron Stensvad DMD

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503-233-4871

MEDICAL HISTORY

Name _____ Date of Birth _____ Date _____

Emergency contact:

Name	Phone	Cell	Relationship to patient
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Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? No Yes Please explain: _____

Are you taking any prescription / over-the-counter drugs? No Yes
(including vitamin supplements, herbal supplements)

Please list each one _____

Do you take an antibiotic prior to dental treatment? No Yes Name: _____

Have you ever had any of the following diseases or medical problems?

- | | | | | | |
|---|--|---|--|---|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> <input type="checkbox"/> Heart Attack/ Stroke | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> Swelling of Feet/Ankles | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> Jaw Pain/Headaches |
| <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> Heart Murmur/Prolapse | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> Prolonged Cortisol/Steroid | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> Epilepsy/Seizures/Fainting |
| <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> Pacemaker | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> Frequent Headaches |
| <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> Rheumatic/Scarlet Fever | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> Hepatitis/Jaundice | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> Chest Pain/Angina | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> Liver Disease | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> Shingles/Rashes |
| <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> Arthritis | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> Ulcers/Colitis | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> Fever Blisters |
| <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> Artificial Pins/Joints | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> Asthma/Bronchitis | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> Cancer |
| <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> High or Low Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> Emphysema | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> Abnormal Bleeding/Anemia | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> Drug/Alcohol Abuse |
| <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> TB/Tuberculosis | | Tobacco _____/day |
| | | | | | Alcohol _____/week |

Osteoporosis Medication?: _____

Hospitalized for any reason in the last 5 years? Explain: _____

FOR WOMEN Are you taking birth control pills? No Yes Are you pregnant? No Yes

Are you nursing? No Yes Week# _____

Are you allergic to any of the following drugs?

- | | | | | | | | |
|---|--|---|--|---|--|---|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> <input type="checkbox"/> Penicillin | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> <input type="checkbox"/> Dental Anesthetics | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> <input type="checkbox"/> Latex |
| <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> Aspirin | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> Epinephrine | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> Codeine | | |

Please list any other drugs that you are allergic to: _____

Physicians Name: _____ Phone #: _____

Pharmacy Name: _____ Phone #: _____

I agree that the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my (or patients) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature _____ Date _____

