NEHALEM BAY
HEALTH CENTER & PHARMACY
COMPASSIONATE COMMUNITY CARE
885 Nehalem Blvd | PO Box 176 | Wheeler, OR 97147 | 1-800-368-5182 | Fax: 1-844-712-3001 | nehalembayhealth.org

Dental Medical History Form

Patient Information

Name: _____

Date of Birth: ____ / ____ / _____

Physician's Name:
_____
Physician's Phone:

Medical History

Please circle any of the following conditions you currently have or have had in the past:

AIDS / HIV	Depression	Infective Endocarditis
Allergies (seasonal or environmental)	Diabetes Type I	Kidney Disease
	Diabetes Type II	Liver Disease
Anemia	Eating Disorder	Mitral Valve Prolapse
Angina	Epilepsy / Seizures	Osteoporosis
Anxiety	Fainting / Dizziness	Pacemaker
Arthritis	GERD / Acid Reflux	PTSD
Artificial Joint	Heart Attack	Radiation Therapy
Artificial Heart Valve	Heart Disease	Respiratory Disease
Asthma	Heart Murmur	Rheumatic Fever
ADHD	Heart Surgery	Schizophrenia
Autoimmune Disease	Hepatitis A	Stroke / TIA
Bipolar Disorder	Hepatitis B	Substance Use Disorder
Bleeding Disorder	Hepatitis C	Thyroid Disease
Cancer	Oral Herpes	Tuberculosis
Chemotherapy	High Blood Pressure	Other:
COPD / Emphysema	High Cholesterol	_____

If you circled any conditions above, please provide details (type, year diagnosed, treatment, or current status):

Allergies

Are you allergic to any of the following? Circle all that apply:

Penicillin	Aspirin	Sulfa Drugs	Anesthetics
Latex	Codeine	Local	Other:

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Medications

Please list all medications, vitamins, and supplements you are currently taking:

Medical Questions

1. Are you currently under a physician's care?
   YES / NO
   If yes, explain:
   _____
2. Have you been hospitalized or had major surgery in the past 5 years?
   YES / NO
   If yes, explain:
   _____
3. Do you require antibiotics before dental treatment?
   YES / NO
4. Do you take blood thinners?
   YES / NO
5. Do you use tobacco?
   YES / NO
6. Do you drink alcohol?
   YES / NO
7. Have you ever taken bisphosphonates or other medications for bone density or cancer treatment?
   YES / NO
8. Do you have any disease, condition, or problem not listed on this form? Please explain:

For Female Patients

Are you pregnant? YES / NO

Are you nursing? YES / NO

If yes, due date: _____

Patient Certification

I certify that the information provided is accurate and complete to the best of my knowledge. I will notify the dental office of any changes in my medical history.

Patient or Parent/Guardian Signature: _____ Date: _____

Dentist Signature: _____ Date:

_____