UMPQUA COMMUNITY HEALTH CENTER

Medical and Dental History

Patient Name:_____Date of Birth:_____Today's Date:_____

Patient Medical History:

Are you in good health? Yes No Has there been any change in your general health within the past year? Yes No

Are you under the care of a physician or medical provider? Yes No Physician: _____
Office Phone: _____ Date of Last Exam:_____If so, what is the condition being treated?_____

Are you taking any medication(s) including nonprescription? Yes No If yes, please list medications and what condition they are being taken for.

Medications:	Conditions:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are you allergic or have sensitivity to any drug/medications? Yes No
If yes, please list the drug/medication and the reaction:
_____

Preferred Pharmacy: _____

Women Only:
Are you currently pregnant or think you may be pregnant?
Yes No Are you nursing? Yes No
I acknowledge that antibiotics may decrease the effectiveness of birth control.

Please indicate if you have or have had any of the following:

____AIDS
____Alcohol Dependency
____Anemia
____Arthritis
____Artificial Heart Valve
____Asthma
____Bleeding Disorders
____Blood Disease
____Cancer
____Cancer Treatment
____Chemical Dependency
____Chest Pain
____Diabetes
____Dizziness
____Easily Winded
____Eating Disorder
____Emphysema
____Epilepsy
____Fainting
____Frequently Tired
____Glaucoma
____Hay fever
____Head Injuries
____Heart Attack
____Heart Defect
____Heart Disease
____Heart Murmur
____Hepatitis
____High Blood Pressure
____High Cholesterol
____HIV
____Jaundice
____Joint Replacement
____Kidney Disease
____Liver Disease
____Low Blood Pressure
____Osteoporosis
____Pacemaker
____Psychiatric Disorders
____Radiation Treatment
____Respiratory Problems
____Rheumatic Fever
____Seizures
____Sexually Transmitted Disease
____Sinus Problems
____Smokeless Tobacco Use
____Smoker
____Stomach Problems
____Stroke
____Surgical Implants
____Thyroid Problems
____Tuberculosis
____Tumors
____Ulcers
Other: _____

Patient Dental History:

Prior Dentist: _____ Office Phone: _____ Last Date Seen: _____

Please check all that apply to you:

____Do your gums bleed while brushing or flossing?
____Are any of your teeth causing you pain today?
____Do you have any sores or lumps in/near your mouth?
____Do you clench or grind your teeth?
____Do you have frequent headaches?
____Have you had any head, neck or jaw injuries?
____Have you ever had prolonged bleeding following an extraction?

I certify that I have read and understand the above information and to the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

_____
Patient signature (parent or legal guardian) Date

Reviewed by:_____
Dentist Signature Date