CLACKAMAS Health Centers

Name: _____
MRN: _____
DOB: _____/_____/_____
(Patient Label Required)

Dental Medical History

1. Date of last dental check/cleaning:_____
2. Do you brush and floss your teeth and mouth daily? Yes No
3. Do you have dental pain, bleeding gums, or sensitive teeth? Yes No
4. Are you pregnant? Yes No Due Date: _____
5. Do you have allergies to any medications or to latex? Yes No
   a. If Yes, explain:_____
6. Are you taking prescription, non-prescription, or herbal medications? Yes No
   a. If Yes, explain:_____
7. Do you use fluoride rinses or supplements? Yes No
8. Please circle any of the following conditions you have or have had in the past:

Abuse as an adult (victim)	Depression	Meningitis
Abuse as a child (victim)	Diabetes	Mental Health Disorder
ADD/ADHD	Drug Addiction	MRSA Infection
Alcoholism	Emphysema/COPD	Myocardial Infarction
Allergies	Glaucoma	Nerve/Muscle Disease
Anemia	Heart Disease	Osteoporosis
Anxiety	Heart Failure	Pacemaker
Arthritis/Joint Disorder	Heart Murmur	Seizures
Asthma	Heart Endocarditis	Sickle Cell Anemia
Autism	History of blood transfusion	STD
Broken Jaw	HIV/AIDS	Stomach Ulcers
Cancer/Chemotherapy	Hyperlipidemia	Stroke
Cataracts	Hypertension	Thyroid Disease
Clotting Disorder	Kidney Disease	Tuberculosis
COPD	Liver Disease	

9. Have you ever had an injury to your face or jaw, or have jaw pain? Yes No
10. Have you had a recent illness, hospitalization, or surgery? Yes No
    a. If Yes, explain:_____
11. Have you ever had problems associated with dental treatment? Yes No
12. Have you, or do you currently use tobacco/nicotine products? Yes No
    a. If Yes:
       i. Cigarettes,___Packs per day for___years
       ii. Chewing tobacco
       iii. Cigars
       iv. E-cigarettes/vape

    Quit date? _____
13. Have you had excessive bleeding requiring medical treatment? Yes No
14. Is there anything in particular that might cause you anxiety by coming to the dentist today? Yes No

    A. If yes, explain:_____

Patient Signature:_____Date:_____

Provider Signature:_____Date:_____