

Name \_\_\_\_\_

Date \_\_\_\_\_

# 1 Medical History

Are you in good health? YES \_\_\_ NO \_\_\_

Are you currently under the care of a physician? YES \_\_\_ NO \_\_\_

If yes, please explain: \_\_\_\_\_

Physician's name: \_\_\_\_\_

Phone: \_\_\_\_\_

Please list all medications currently being taken:  
\_\_\_\_\_  
\_\_\_\_\_

Do you smoke or use tobacco in any form: YES \_\_\_ NO \_\_\_

Have you ever had any of the following? Please circle each one.

AIDS/HIV	Y	N	Hepatitis	Y	N
Allergies	Y	N	High Blood Pressure	Y	N
Anemia	Y	N	Kidney Disease	Y	N
Arthritis	Y	N	Liver Disease	Y	N
Artificial Joints	Y	N	Mental Disorders	Y	N
Artificial Heart Valve(s)	Y	N	Mitral Valve Prolapse	Y	N
Blood Disease	Y	N	Nervous Disorders	Y	N
Cancer	Y	N	Pacemaker	Y	N
Cold Sores/Herpes	Y	N	Pregnancy (Due _____)	Y	N
Diabetes	Y	N	Recent Illness	Y	N
Dizziness	Y	N	Respiratory	Y	N
Eating Disorders	Y	N	Rheumatic Fever	Y	N
Epilepsy	Y	N	Sinus Problems	Y	N
Fainting	Y	N	Tuberculosis	Y	N
Glaucoma	Y	N	Ulcers	Y	N
Heart Murmur	Y	N	Penicillin Allergy	Y	N
Hay Fever	Y	N	Asthma	Y	N
Fen-Phen	Y	N			

ARE YOU ALLERGIC TO OR REACTED ADVERSELY TO:

Local Anesthetic	Y	N	Aspirin	Y	N
Penicillin	Y	N	Codeine	Y	N

Summary of medical history

**WOMEN ONLY** Are you pregnant? YES \_\_\_ NO \_\_\_ Due date \_\_\_\_\_

Are you nursing? YES \_\_\_ NO \_\_\_

Are you using birth control pills? YES \_\_\_ NO \_\_\_

Medical history update  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# 2 Dental History

Is there anything about your teeth that presently concerns you? \_\_\_\_\_

What do you feel is the most important thing we can do for you at this time? \_\_\_\_\_

How would you describe the condition of your teeth?

Good \_\_\_ Fair \_\_\_ Poor \_\_\_

How would you describe the condition of your gums?

Good \_\_\_ Fair \_\_\_ Poor \_\_\_

Are you currently having pain or discomfort in your teeth or gums?

YES \_\_\_ NO \_\_\_ If yes, please explain: \_\_\_\_\_

Are you anxious about dental treatment? \_\_\_\_\_

Has the fear of discomfort kept you from regular care? \_\_\_\_\_

Yes \_\_\_ No \_\_\_

Yes \_\_\_ No \_\_\_

Please describe previous experiences with dental offices \_\_\_\_\_

Dental Specialists seen \_\_\_\_\_

How do you feel about what was done in your mouth?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## (DOCTOR USE ONLY)

### CONDITIONS

- Bleeding Gums
- Would Like to Improve Smile
- Would Like to Have Whiter Teeth
- Discoloration/Stain
- Concern About Mercury
- Concern About Dental Materials
- TMD/TMJ Problems
  - Frequent Headaches
  - TMJ Pain
  - TMJ Noise
  - Limited Opening
  - Ear Congestion
  - Ringing in the Ears
  - Difficulty Swallowing
  - Clenching - Bruxing
  - Facial Pain
  - Neck Pain
  - Postural Problems
  - Tingling Fingers
  - Back Pain
  - Trauma to Jaw

### Sensitive Teeth

- Difficulty Chewing
- Thermal Sensitivity
- Loose Teeth
- Rough Areas

### Tooth Wear

- Chipped Teeth
- Worn Edges

### Alignment

- Spacing
- Crowding
- Crooked

### Odor/Taste

- Food Trap Areas

Notes: \_\_\_\_\_

# 3 Consent

I understand that, to the best of my knowledge, the questions on this form have been accurately answered. I understand it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status or condition.

I authorize the dental staff to perform all necessary dental procedures that I may need with my informed consent. I also give permission to the doctor or his staff to use any photos he may take to be used for lecturing, publishing, or educational purposes.

Signature \_\_\_\_\_ Date \_\_\_\_\_



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