

Brock A. Van Gordon, DMD, P.C.

Family and Cosmetic Dentistry

30045 SW Parkway Avenue

Wilsonville, OR 97070

Patient Medical History Information

Patient's Name (Please Print) _____

Patient's Medical Doctor _____ City _____

Please answer all of the following questions below.

1. Are you currently under any medical treatment? Yes___ No___

If yes, explain _____

2. Are you taking any medications, injections or drugs at present time?

Yes___ No___ If yes, please list _____

3. Are you allergic to any medication or drugs including penicillin, codeine, aspirin, local anesthetic, latex, etc.? Yes___ No___

If yes, please list _____

4. Have you had any serious illness or operations in the past 5 years?

Yes___ No___ If yes, please list _____

5. Do you have any bleeding tendencies? Yes___ No___

6. Do you smoke cigarettes, cigars or use any tobacco products? Yes___ No___

7. Please answer the following by marking yes or no.

Yes	No		Yes	No	
___	___	AIDS/ HIV	___	___	Blood Transfusion
___	___	Diabetes	___	___	Chemotherapy
___	___	Artificial Joints	___	___	Drug Addiction
___	___	Asthma	___	___	Glaucoma
___	___	Chest Pains	___	___	Heart Murmur
___	___	Epilepsy	___	___	Hepatitis A B C
___	___	Heart Attack	___	___	Kidney Disease
___	___	Heart Trouble	___	___	Medical Treatment
___	___	High Blood Pressure	___	___	Rheumatic Fever
___	___	Liver Disease	___	___	Shortness of Breath
___	___	Psychiatric Treatment	___	___	Thyroid Disease
___	___	Sinus Trouble	___	___	Ulcer
___	___	Stroke	___	___	Tuberculosis
Other _____					

8. **For Women Only** are you pregnant? Yes___ No___ If yes, due date? _____

Are you nursing? Yes___ No___

I certify that the above is true and complete to the best of my knowledge. This for is

completed by _____ Today's date _____

Signature

If not patient, title of relationship _____