Trenton LeBaron, D.M.D.

3975 River Rd. N. Ste. #5
Keizer, OR 97303

503-393-9106
www.keizersmilecenter.com

Patient Name: ______________________________ Date of Birth: ____________________

DENTAL HISTORY

Check if you have had problems with any of the following:

[ ] Bad breath
[ ] Bleeding gums
[ ] Clicking or popping jaw
[ ] Food collection between teeth
[ ] Grinding teeth
[ ] Loose teeth or broken fillings
[ ] Periodontal treatment
[ ] Sores or growths in the mouth
[ ] Sensitivity to hot or cold
[ ] Sensitivity when biting
[ ] Sensitivity to sweets

How often do you brush? ____________________ How often do you floss? ____________________

MEDICAL HISTORY

Please check all that apply, and provide details on the line below.

[ ] Are you under a physician's care now?
[ ] Have you been hospitalized or had a major operation?

Details: ____

Women, are you: [ ] Pregnant - #weeks ______ [ ] Taking oral contraceptives [ ] Nursing

Medications.

Please list *all medications* and/or dietary supplements you are currently taking: ____________________

____

____

Are you *allergic* to any medications?

If yes, please list: ____

Please mark any of the following you may have had, or have at present:

CARDIOVASCULAR
[ ] Congestive Heart Failure
[ ] Heart Attack
[ ] Angina or Chest Pain
[ ] High Blood Pressure
[ ] Congenital Heart Defect
[ ] Artificial Heart Valve
[ ] Pacemaker
[ ] Coronary Bypass
[ ] Coronary Angioplasty
[ ] Heart Transplant
[ ] Aneurysm
[ ] Past Endocarditis
[ ] Other Heart Problem

HEMATOLOGIC
[ ] Anemia
[ ] Hemophilia
[ ] Leukemia
[ ] Excessive Bleeding

NEUROLOGIC
[ ] Glaucoma
[ ] Hearing Loss
[ ] Severe Headaches
[ ] Fainting or Dizzy Spells
[ ] Stroke
[ ] Epilepsy or Seizures
[ ] Psychiatric Treatment

GASTROINTESTINAL
[ ] Diabetes Type 1 Type 2
[ ] Gastric Ulcers or GERD
[ ] Hepatitis or Liver Disease
[ ] Eating Disorder

PULMONARY
[ ] Sinus Trouble
[ ] Allergies or Hives
[ ] Asthma
[ ]Chronic Cough/Bronchitis
[ ] Emphysema
[ ] Tuberculosis (TB)
[ ] Breathing Difficulties

DERMAL/MUSCULOSKELETAL
[ ] Arthritis
[ ] Systemic Lupus
[ ] Artificial Joint

OTHER CONDITIONS
[ ] Frequent Sore Throats
[ ] Use Tobacco – Smoked Chew
[ ] Use Alcohol
[ ] Use Other Drugs ____________
[ ] Drug or Alcohol Addiction
[ ] Tumor or Cancer
[ ] Radiation Therapy
[ ] Chemotherapy

Have you ever had any serious illness not listed above? ____

To the best of my knowledge, the questions on this form have been accurately answered. I understand providing incorrect information can be dangerous to my (or my patient's) health. It is my responsibility to inform the dental office of any changes to my medical status.

____ ____________________

Patient Signature **Date**