Oregon Mobile Hygiene

NAME _____ **Date of Birth:** ___/___/_____

Community Name_____

DENTAL HISTORY

Name of Dentist_____ City _____ Phone (____)_____

Antibiotic Pre-medication needed for dental treatment in the past? _____ **Yes** _____ **No**

Date of last dental care _____ **Check (✓) if you have <u>problems</u> with any of the following:**

- □ Bad breath or taste
- □ Bleeding gums
- □ Sores or growths in your mouth
- □ Food collection between teeth
- □ Jaw Pain
- □ Your partial or dentures
- □ Loose teeth or broken fillings
- □ Dry Mouth
- □ Sensitivity to cold
- □ Persistent swollen neck glands
- □ Sensitivity to hot
- □ Sensitivity to sweets
- □ Sensitivity when biting

Other_____

MEDICAL HISTORY

PHYSICIAN'S NAME _____ Address_____

Phone (_____)_____ _____

Please describe medical conditions that are not listed below

_____

Check (✓) if you have or had any of the following: □ **<u>Artificial Heart Valve</u>** □

Parkinson's □ Alzheimer's □ Cerebral Palsy □ Multiple Sclerosis □ Dementia

□ Anemia □ Cough, Persistent □ Hepatitis _____

□ Anxiety □ Cough up Blood □ High Blood Pressure

□ Arthritis □ Depression □ HIV/AIDS

□ ***Artificial Heart Valves*** □ Diabetes Type I or II □ ***Infective Endocarditis*** □ Shortness of Breath

□ Artificial Joints □ Epilepsy/Seizures □ Kidney Problems □ Stroke

□ Asthma □ Fainting □ Liver Disease □ Swollen Feet/Ankles

□ Back Problems □ Gastrointestinal Disease □ Neurological Disorders □ Thyroid Problems

□ Blood Disease/Disorder □ Glaucoma □ Osteoporosis □ Tobacco Habit

□ Cancer/Chemotherapy □ Headaches/Migraines □ Pacemaker □ Tuberculosis

□ Chemical Dependency □ Heart Attack □ Radiation Treatment

□ Circulatory Problems □ Heart Problems □ Respiratory Disease

□ Cortisone Treatments other_____

MEDICATIONS

_____

_____

_____

_____

ALLERGIES

- ☐ Aspirin
- ☐ Iodine
- ☐ Codeine
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Latex
- ☐ Other_____

SIGNATURE

□ The above information is accurate and complete to the best of my knowledge. I will not hold Oregon Mobile Hygiene or any member of the staff responsible for any errors or omissions that I have made in the completion of this form.

SIGNATURE:_____ **Date** ____/____/_____

Name _____**Relationship to Patient**_____