Granite Dental
Dr. David Keller
215 NW 78th Street
Vancouver, WA 98665
360-693-2577

Medical History

Name: _____ Best Number to reach you: _____
Birthday: _____ Email: _____

Do you have any of the following conditions?

Anxiety/Fear at the Dental Office	Y	N	Arthritis, Rheumatoid Arthritis, Lupus	Y	N
Asthma/Emphysema, COPD	Y	N	Blood Thinner (coumadin, Warfarin, etc.)	Y	N
Bleeding Gums when brushing or flossing	Y	N	Cancer (type)	Y	N
Heart Attack in the past 2 years	Y	N	Diabetes Type I or II (circle) Diagnosis Date	Y	N
High Blood Pressure	Y	N	Endocarditis, Rheumatic Fever, Scarlet Fever	Y	N
Osteoporosis	Y	N	Frequent Headaches	Y	N
Radiation or Chemo Therapy	Y	N	Hepatitis Type A B C (circle) Diagnosis Date:	Y	N
Reflux or GERD (circle)	Y	N	Joint Surgery in the past 2 years Which Joint:	Y	N
Stomach/GI Ulcers	Y	N	Periodontal Disease/Gingivitis	Y	N
Stroke/TIA when:	Y	N	Family History of Periodontal Disease	Y	N
Tuberculosis	Y	N	Sleep Apnea or Snoring (circle)	Y	N
Unhappy or Depressed	Y	N	Viral Infection (HIV/AIDS, HPV) (circle)	Y	N

Indicate on the following scale how often you have been bothered by either of the problems over the last two weeks: 0=Not at all; 1=several days; 2=more than half the days; 3=nearly every day

Little Interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3

Allergies (circle) LATEX PENICILLIN
Please list any other allergies: _____

Please list all of your current medications:
_____
_____
_____

Is there anything specific you would like the dentist to look at? _____
Is there anything you would like to discuss with the dentist? _____

NOTES: _____
_____
_____
_____
_____

Patient Signature:_____ Date:_____

Doctor Signature: _____ Date:_____

I have reviewed with the patient all indicated medical conditions, medications, and their impact on previous, current, and anticipated treatment in my office.