PATIENT MEDICAL HISTORY

Kent Burnett DDS

1711 NW Grant Ave,
Corvallis, OR 97330
(541) 754-1668

420 Smith St
Harrisburg, OR 97446
(541) 995-8234

Please email completed form to: office@kentburnettdds.com

NAME_____DATE OF BIRTH_____

Allergens

- ○ No known allergens
- ○ Antibiotics
- ○ Aspirin
- ○ Barbiturates
- ○ Codeine
- ○ Iodine
- ○ Latex
- ○ Local anesthetics
- ○ Metals
- ○ Penicillin
- ○ Plastic
- ○ Sedatives
- ○ Sleeping pills
- ○ Sulfa drugs

Other:_____

Current Medications

Medicine	Dosage/Frequency	Reason

Other:_____

Medical History

Significant	Medical Condition	Current Never	Current	Past
○	Acid Reflux	○	○	○
○	Anemia	○	○	○
○	Atherosclerosis	○	○	○
○	Arthritis	○	○	○
○	Asthma	○	○	○
○	Autoimmune Disorder	○	○	○
○	Bleeding Easily	○	○	○
○	Blood Pressure - High	○	○	○
○	Blood Pressure - Low	○	○	○
○	Bruising Easily	○	○	○
○	Cancer	○	○	○
○	Chemotherapy	○	○	○
○	Chronic Fatigue	○	○	○
○	Chronic Pain	○	○	○
○	COPD	○	○	○
○	Coronary Heart Disease	○	○	○

Significant	Medical Condition	Current Never	Current	Past
○	Current Pregnancy	○	○	○
○	Depression	○	○	○
○	Diabetes	○	○	○
○	Difficulty Sleeping	○	○	○
○	Dizziness	○	○	○
○	Emphysema	○	○	○
○	Epilepsy	○	○	○
○	Excessive Daytime Sleepiness	○	○	○
○	Fibromyalgia	○	○	○
○	Glaucoma	○	○	○
○	Gout	○	○	○
○	Heart Attack	○	○	○
○	Heart Murmur	○	○	○
○	Heart Pacemaker	○	○	○
○	Heart Valve Replacement	○	○	○
○	Hemophilia	○	○	○

Medical History (continued)

Significant	Medical Condition	Current: Never	Past
○	Hepatitis	○	○
○	Hypertension	○	○
○	Hypoglycemia	○	○
○	Immune System Disorder	○	○
○	Insomnia	○	○
○	Ischemic Heart Disease	○	○
○	Kidney Problems	○	○
○	Liver Disease	○	○
○	Meniere's Disease	○	○
○	Mitral Valve Prolapse	○	○
○	Mood Disorder	○	○
○	Multiple Sclerosis	○	○
○	Muscular Dystrophy	○	○
○	Nasal Allergies	○	○
○	Neuralgia	○	○

Other:_____

Significant	Medical Condition	Current: Never	Past
○	Osteoarthritis	○	○
○	Osteoporosis	○	○
○	Parkinson's disease	○	○
○	Prior Orthodontic Treatment	○	○
○	Radiation Treatment	○	○
○	Rheumatic Fever	○	○
○	Rheumatoid Arthritis	○	○
○	Sinus Problems	○	○
○	Sleep Apnea	○	○
○	Stroke	○	○
○	Tendency For Ear Infections	○	○
○	Thyroid Disorder	○	○
○	Tuberculosis	○	○
○	Tumors	○	○
○	Urinary Disorders	○	○

Other:_____

Confidential Medical History

Significant	Medical Condition	Current: Never	Past
○	Recreational Drugs	○	○

Other:_____

Significant	Medical Condition	Current: Never	Past
○	HIV/AIDS	○	○

Other:_____

Surgical Operations

○ Appendectomy	○ Heart	○ Thyroid
○ Back	○ Hernia Repair	○ Tonsillectomy
○ Ear	○ Lung	○ Uvulectomy
○ Gallbladder	○ Nasal	○ Periodontal

Other:_____

Family History

Has any member of your family (parent, sibling or grandparent) had:

○ Cancer	○ Stroke	○ Father Snores
○ Heart Disease	○ Sleep Disorder	○ Mother Snores
○ Diabetes	○ Obesity	○ Father Has Sleep Apnea
○ High Blood Pressure	○ Thyroid Disorder	○ Mother Has Sleep Apnea

Social History

Patient's Occupation:_____ Employer:_____

Tobacco Use: ○ Never Smoked ○ Current Smoker ○ Quit When:_____

If current smoker: # of packs per day:_____ # of years:_____

Other tobacco products: ○ Pipe ○ Cigar ○ Snuff ○ Chew

Alcohol Use: Do you drink alcohol? ○ Yes ○ No If yes, # of drinks per week:_____

Caffeine Intake: ○ None ○ Coffee/Tea/Soda If yes, # of cups per day:_____

Additional:

Regular Exercise ○ Yes ○ No

Patient Signature

Because of HIPAA federal regulations protecting your privacy, we wish to inform you that we will release no information about you without your consent. By agreeing to this consent, you permit the release of any information to or from your dental practitioner as required including a full report of examination findings, diagnosis and treatment program to any referring or treating dentist or physician. You understand that you are financially responsible for all charges whether or not paid by insurance. Your dental practitioner may use your health care information and may disclose such information to your insurance company(ies) and their agents for the purpose of obtaining payment for service and determining insurance benefits or the benefits payable for related services.
I certify that the medical history information is complete and accurate.

X _____ DATE_____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR