Gary S. Hongo, DMD

9732 SE Washington Street, Suite H, Portland, OR 97216

Patient Name: _____ Date: _____

MEDICAL HISTORY

General Health (please check)

EXCELLENT __ GOOD____FAIR ___POOR ____ Date of last physical examination: _____

Physician's Name:_____ City: _____ State: _____Phone:_____

_____

Have you been hospitalized or had a serious illness within the past 5 years?_____ If yes, state conditions:

_____ Date _____

_____ Date _____

Are you presently taking any medication drugs or pills (including children's fluoride)? _____ If yes, please list drugs:

_____

_____

_____

List any drug allergies:_____

_____

All patients: Do you smoke/chew? _____How much?_____**Women:** Pregnant?___Due Date_____

Have you ever had? (please check if YES)

___Rheumatic Fever	___Tumor/Growth	___High Blood Pressure	___Bleeding Problems
___Heart Murmur	___Cancer Type_____	___Anemia	___Jaundice
___Artificial Joints/Implants	___Arthritis	___Diabetes	___Epilepsy
___Heart Trouble	___Asthma	___HIV	___Ulcers
___Heart Attack	___Kidney Disease	___AIDS	___Fainting Spells
___Pacemaker/Bypass	___Glaucoma	___Hepatitis: Type_____	___Convulsions
___Stroke	___Tuberculosis	___Venereal Disease: Type_____	
___Metal Allergy		___Oral Piercing: Date_____	

Any additional comments or conditions not listed above:

SIGN HERE!!

_____ _____ _____ _____ _____

Print Name of Patient | Signature of Responsible Party | Relationship to Patient | Date

Reviewed by Dr.:_____**Date:**_____

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Office Use Only

Medical History Update

Date:_____Changes_____

_____Reviewed by Dr.:_____

Date:_____Changes_____

_____Reviewed by Dr.:_____

Date:_____Changes_____

_____Reviewed by Dr.:_____

Date:_____Changes_____

_____Reviewed by Dr.:_____

Date:_____Changes_____

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Date:_____Changes_____

_____Reviewed by Dr.:_____