Springhill Dental and Orthodontics
637 NW Hickory St #110, Albany, OR 97321
(541) 406 3500
springhilldentalalbany.com

HEALTH HISTORY

Patient Name: _____ **DOB:** _____
FIRST LAST

General Health Information

Are you currently under the care of a physician?	☐ Yes ☐ No
Physician phone number:	
Date of last physical exam:	
Are you presently being treated for any injury or illness?	☐ Yes ☐ No
Have you ever been hospitalized for an injury or illness?	☐ Yes ☐ No
Are you pregnant or planning to become pregnant?	☐ Yes ☐ No
Are you currently breastfeeding?	☐ Yes ☐ No
Are you required to pre-med with antibiotics before dental treatment?	☐ Yes ☐ No
Do you use alcohol?	☐ Yes ☐ No
Do you use or have you ever used tobacco?	☐ Yes ☐ No

Allergies

Are you allergic to any of the following? Please check any that apply: ☐ **No Known Allergies**

☐ Anesthetic ☐ Aspirin ☐ Codeine ☐ Ibuprofen ☐ Iodine ☐ Latex ☐ Penicillin ☐ Sulfa

☐ Other - Please list any other allergies or allergic reactions you may have:

Medical Conditions

Please check all conditions that you have history of or are currently being treated for:

Do you have a history or are currently being treated for any Digestive conditions?	☐ Yes ☐ No
Do you have a history or are currently being treated for any Heart or Circulatory conditions?	☐ Yes ☐ No
Do you have a history or are currently being treated for any Neurological conditions?	☐ Yes ☐ No
Do you have a history or are currently being treated for any Lung or Breathing conditions?	☐ Yes ☐ No
Do you have a history or are currently being treated for any Autoimmune conditions?	☐ Yes ☐ No
Head or neck injuries?	☐ Yes ☐ No
Artificial Joint or revision surgery of joint? If yes, when?	☐ Yes ☐ No
High cholesterol?	☐ Yes ☐ No
History of cancer?	☐ Yes ☐ No
Tumor or abnormal growth?	☐ Yes ☐ No
Radiation therapy?	☐ Yes ☐ No
Chemotherapy?	☐ Yes ☐ No

HIV / AIDS?	☐ Yes	☐ No
Osteoporosis / osteopenia?	☐ Yes	☐ No
Type I or Type II diabetes? Latest A1c and date	☐ Yes	☐ No
Anemia?	☐ Yes	☐ No
Kidney disease?	☐ Yes	☐ No
Liver disease?	☐ Yes	☐ No
Thyroid disease?	☐ Yes	☐ No
Tuberculosis?	☐ Yes	☐ No
Measles / chicken pox?	☐ Yes	☐ No
Any other medical condition we should know of? If yes, please list below.	☐ Yes	☐ No

Medications

Please check all medications you are currently taking:

Are you taking any pain medications?	☐ Yes	☐ No
Are you taking any Antidepressants or Anxiety medications?	☐ Yes	☐ No
Are you taking any Diabetes, Cholesterol, or Blood Pressure medications?	☐ Yes	☐ No
Are you taking any Allergy or Asthma medications?	☐ Yes	☐ No
Are you taking any Antibiotics?	☐ Yes	☐ No
Are you currently taking any other medications or dietary supplements?	☐ Yes	☐ No

Please list all medications you are currently taking in the spaces below:
EXISTING PATIENTS Check the box next to any medication no longer being taken.

1. ☐	6. ☐
2. ☐	7. ☐
3. ☐	8. ☐
4. ☐	9. ☐
5. ☐	10. ☐

Patient/Guardian Signature: _____ Date: 09/16/2025

Doctor Signature: _____